

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12715		12710	
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Route 2	
3. NAME OF DECEASED (Type or print)		First Wilbur	Middle M.
4. DATE OF DEATH Ahalt		Last Ahalt	Month 9
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3/11/1878		9. AGE (in years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner, ret.		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Foster Ahalt		14. MOTHER'S MAIDEN NAME Martha Sheffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Minnie Ahalt, Middletown, Md.		Address Route 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Myocardial infarction atmosiderotic heart disease	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-26-1966 , to 2-28-1966 , that (I) (we) last saw the deceased alive on 9/26/1966 , and that death occurred at 11 AM , from the causes and on the date stated above.		22b. DATE SIGNED 9-28-66	
22a. SIGNATURE Robert D. Crouch		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) ROBERT D. Crouch		22d. ADDRESS 806 Toll House Ave, Frederick	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/1/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Lutheran Cemetery		23d. LOCATION (City, town or county) (State) Middletown, Md.	
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.		25a. REC'D BY REGISTRAR DATE OCT 3 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12218

CERTIFICATE OF DEATH

12711

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)																	
a. COUNTY Frederick		a. STATE MARYLAND b. COUNTY Frederick																	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 4 wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural DickersTOWN															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial		d. STREET ADDRESS RTI DickersTOWN																	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) Janice Elaine Ambush		First Janice		Middle Elaine		Last Ambush		4. DATE OF DEATH 9 17 1966		Month 9		Day 17		Year 1966					
5. SEX Female		6. COLOR OR RACE C Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11-26-1948		9. AGE (In years last birthday) 17 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Hours 0		12. IF UNDER 24 HRS. Minutes 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typist (Student)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland										12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Maurice Floyd Ambush		14. MOTHER'S MAIDEN NAME Shirley Johnson										Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-48-8755		17. INFORMANT Maurice Floyd Ambush		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of kidney 1808 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH 3 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 to Sept , 19 66 , that (I) (we) last saw the deceased alive on Sept 17 1966 , and that death occurred at 11 AM , from the causes and on the date stated above.		22b. DATE SIGNED 9/17/66																	
22a. SIGNATURE Le Roy T. Davis		22c. PHYSICIAN'S NAME (Type) Le Roy T. Davis										22d. ADDRESS Professional Bldg, Frederick, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 19-20-1966		23c. NAME OF CEMETERY OR CREMATORIAL St. Pauls Church		23d. LOCATION (City, town or county) (State) Frederick Co. Md													
24. FUNERAL DIRECTOR C. E. Hicks, III		ADDRESS Frederick, md		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE SEP 20 1966													

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2a, b, c & d Film #G380 9/19/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12717

12712

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ill. Ohio		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick R.D.6			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton/ Stone Park		
d. STREET ADDRESS Christopher Patterson/AFB.			d. STREET ADDRESS Christopher Patterson/AFB.		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Oliver	Middle Patrick	4. DATE OF DEATH September 4, 1966	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 26, 1925	9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Flier			10b. KIND OF BUSINESS OR INDUSTRY USAF	11. BIRTHPLACE (State or foreign country) III.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PATRICK ARQUILLA			14. MOTHER'S MAIDEN NAME Rose GUILIER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes			16. SOCIAL SECURITY NO. 347-18-0412	17. INFORMANT USAF Records	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Was in aero plane accident body torn DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. in shreads (b) _____ DUE TO (c) _____					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was in aero plane which exploded			
20c. TIME OF INJURY Month, Day, Year 6-15 p.m. 9/4/66 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> Rural	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rural	20f. (City or town) Frederick, Frederick. Md	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O.Thomas M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) B.O.Thomas, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 22. DATE SIGNED 9/4/66					
Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 9/8/66	23c. NAME OF CEMETERY OR CREMATORIAL FERNCLIFFE	23d. (CITY, TOWN, OR COUNTRY) Dayton OHIO	(State)	
24. FUNERAL DIRECTOR W.W. Chambers 517 1115 82		ADDRESS W.W. Chambers 517 1115 82	25a. RECEIVED BY REGISTRAR SEP 8 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

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SIXTY

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

M

12718

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12713

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN lb Minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 15		d. STREET ADDRESS Route # 6	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JUSTIN	First G.	Middle BOYD	4. DATE OF DEATH September 2 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH June 9, 1940
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Todd Steel	
13. FATHER'S NAME Samuel Daniel Boyd		14. MOTHER'S MAIDEN NAME Missouri Shank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213 40 3303	17. INFORMANT Address Mrs. Sandra Boyd (Same as item # 2)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transsected Aorta INTERVAL BETWEEN ONSET AND DEATH 8/24 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Crushed Chest stating the underlying cause (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stomach by trailer - punch	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10 9-2 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. (City or town) (County) (State) Frederick - Frederick - Md.	
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 6, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR Donald M. Fadelley	ADDRESS M. R. Etchison & Son, Frederick, Maryland	25a. REC'D BY REGISTRAR DATE SEP 7 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

1958

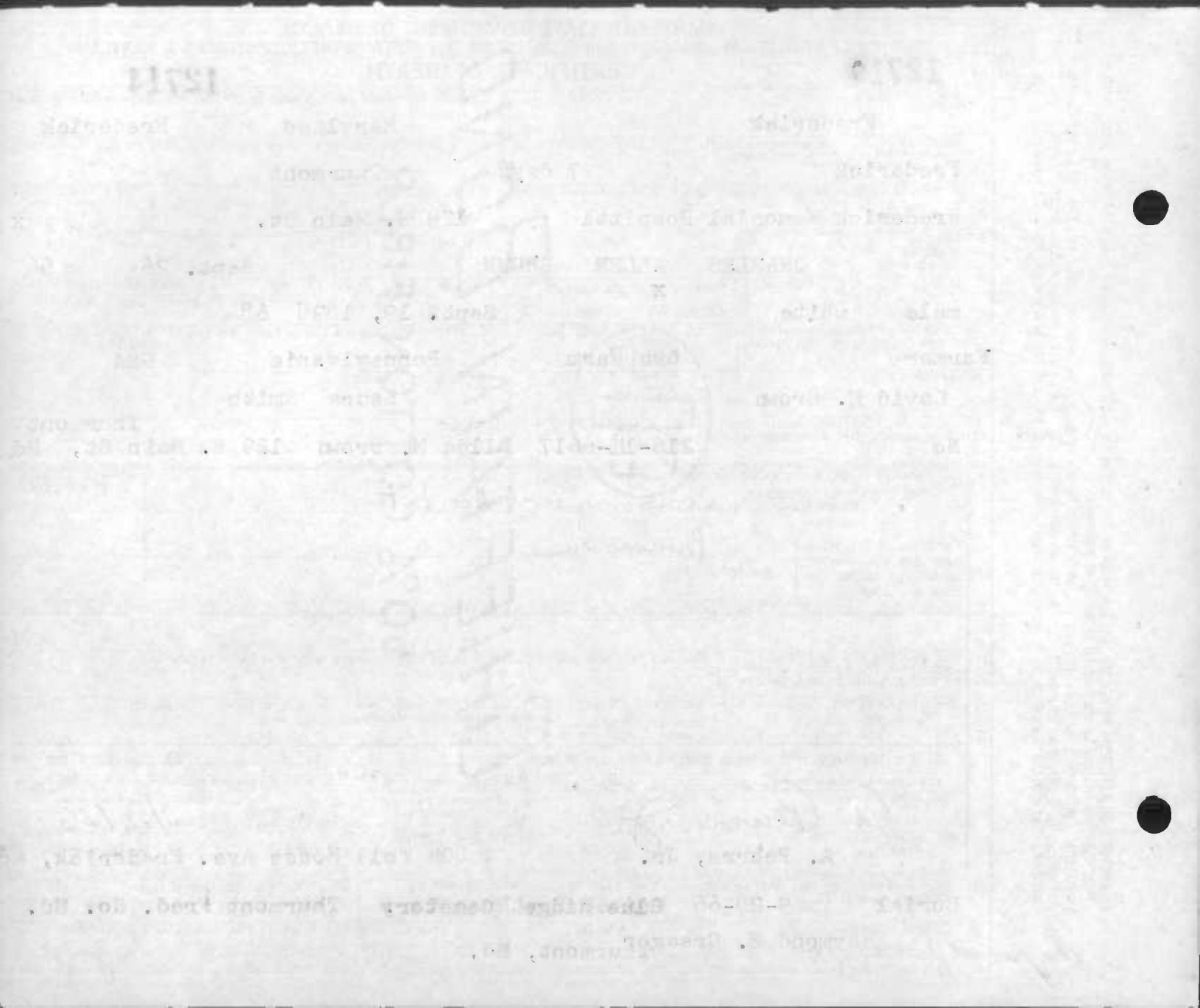
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
Frederick MARYLAND				a. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont 104									
c. LENGTH OF STAY IN 1b 7 days													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 129 E. Main St.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
CHARLES ALLEN BROWN							Sept. 26			1966			
5. SEX				6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS				
male white				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 19, 1898	68 yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm				11. BIRTHPLACE (County & State, or foreign country) Pennsylvania					
12. CITIZEN OF WHAT COUNTRY? USA													
13. FATHER'S NAME David M. Brown				14. MOTHER'S MAIDEN NAME Laura Smith									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-14-6617				17. INFORMANT Hilda M. Brown				Address Thurmont	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Cerebrovascular Accident								INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				Pneumonia									
(b)													
DUE TO cause (a), stating the underlying cause last.													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <i>A. Pearre, Jr.</i>				22b. DATE SIGNED 9/26/66									
22c. PHYSICIAN'S NAME (Type) A. Pearre, Jr.				22d. ADDRESS 804 Toll House Ave. Frederick, Md.									
23a. BURIAL, CREMATION, BURIAL (Specify)				23b. DATE THEREOF 9-28-66				23c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cemetery				23d. LOCATION (City, town or county) (State) Thurmont Fred. Co. Md.	
24. FUNERAL DIRECTOR Raymond E. Creager				ADDRESS Thurmont, Md.								25a. REC'D BY REGISTRAR DATE OCT 3 1966	
												25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH												12715	
1. PLACE OF DEATH a. COUNTY FREDERICK				b. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN lb DOA				b. COUNTY FREDERICK					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LIBERTYTOWN				d. STREET ADDRESS —				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. DATE OF DEATH SEPT 5 1966									
3. NAME OF DECEASED (Type or print)		First RAYMOND		Middle NELSON		Lost BROWN		Month		Day Year			
4. SEX M		6. COLOR OR RACE C		7. MARRIED WIDOWED <input type="checkbox"/>		NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH AUG 2 - 1910		9. AGE (In years last birthday) 56 yrs.			
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) DAY LABORER				10b. KIND OF BUSINESS OR INDUSTRY FOUNDREY				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIAM BROWN				14. MOTHER'S MAIDEN NAME MARGARET BROOKS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 217-16-2563				17. INFORMANT RACHEL BROWN LIBERTYTOWN MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure													
410X													
DUE TO													
(b) Chronic Rheumatic Heart Disease													
DUE TO													
(c) (Mitral & Aortic Insufficiency)													
INTERVAL BETWEEN ONSET AND DEATH													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
BSHD - Pulmonary Emphysema													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)			
										(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>B.O.Thomas</u>													
EXAMINER'S NAME (Type) <u>B.O.Thomas, M.D.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 9/18/66		23c. NAME OF CEMETERY OR CREMATORIUM WESLEY				23d. LOCATION (City or Town) LIBERTYTOWN			
										(County) (State)			
24. FUNERAL DIRECTOR <u>D D Hartler & Sons Libertytown</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 8 1966				25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12721

CERTIFICATE OF DEATH

12716

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 203 East Third St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Edward	Last Cramer
4. DATE OF DEATH Month September	Day 20	Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9 - 1892
9. AGE (in years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Water Dept.	11. BIRTHPLACE (County & State, or foreign country) Frederick County- Md.	
13. FATHER'S NAME Charles F. Cramer		14. MOTHER'S MAIDEN NAME Lula Ent Lambert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 217- 32- 5267	17. INFORMANT Elwood A. Cramer- Route 4-Frederick, Md. 21701	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>123 yrs</i>	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 220 N. Market St.- Frederick, Md. 21701
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1953 , 19, to 9-20 , 19 66 , that (I) (we) last saw the deceased alive on 9-19- 1966 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Rex. R. Martin</i>		22b. DATE SIGNED Sept. 20-1966	
22c. PHYSICIAN'S NAME (TYPE) Rex. R. Martin		22d. ADDRESS 220 N. Market St.- Frederick, Md. 21701	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23-1966	
23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Md. 21701	
24. FUNERAL DIRECTOR Elwood T. Whitmore		25a. ADDRESS M.R. Etchison & Son- Frederick, Md. 21701	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE SEP 22 1966	

MSI

25

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

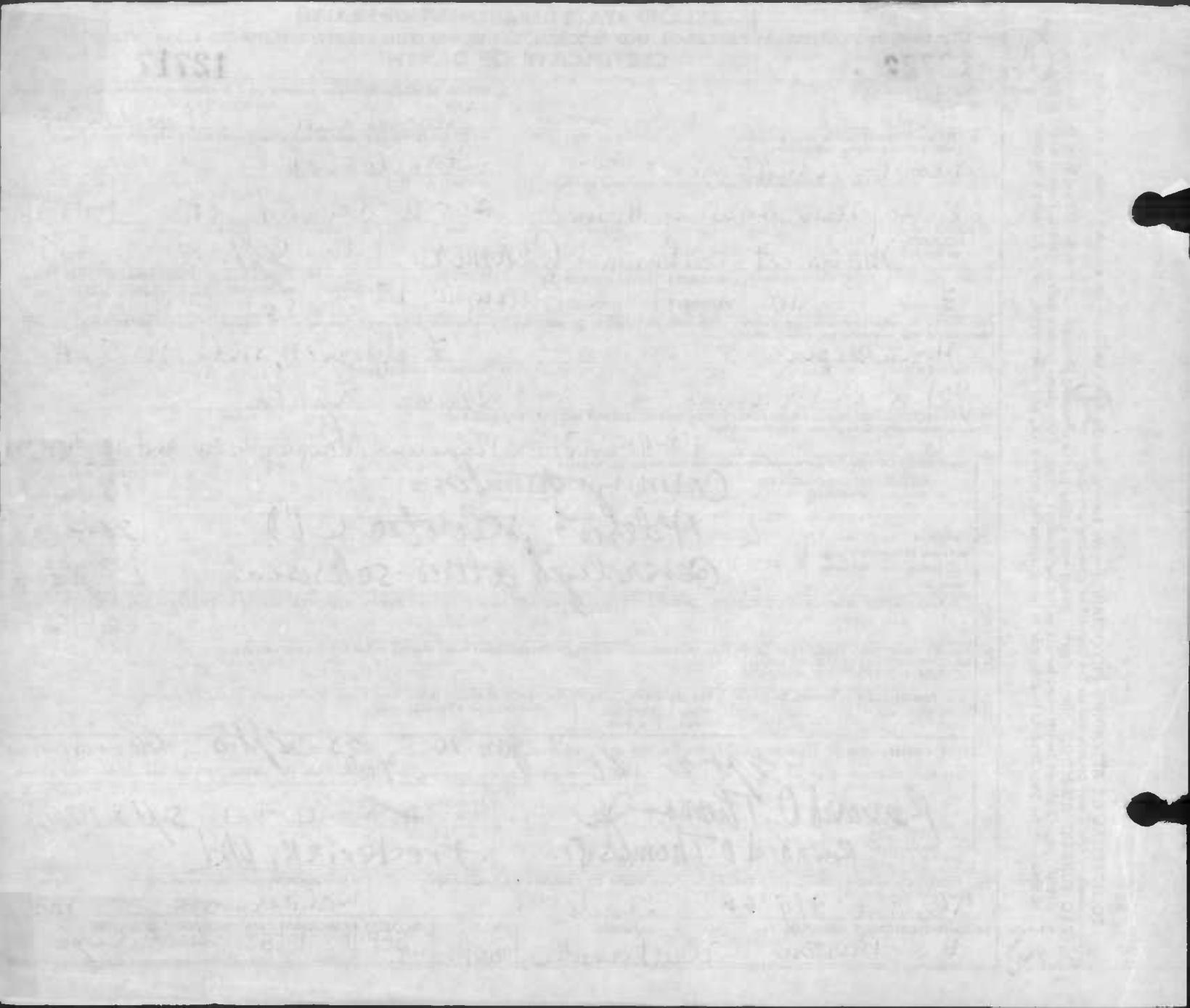
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12722

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - Middletown</i>		c. LENGTH OF STAY IN 16 <i>14 mo.</i>	
d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Valley View Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret Catherine Cramer</i>		First	Middle
4. DATE OF DEATH <i>Sept. 8 1966</i>		Last	Month Day Year
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Aug 10, 1880</i>
9. AGE (in years last birthday) <i>86 yrs.</i>		9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mrs Virginia C. Shippy, 205 W. 2nd St., Fred. Md.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Frederick, md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John D. Cramer</i>		14. MOTHER'S MAIDEN NAME <i>Laura Smith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>413-40-6676</i>	
17. INFORMANT <i>Mrs Virginia C. Shippy, 205 W. 2nd St., Fred. Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)	
		DUE TO <i>Cerebral thrombois</i>	
		DUE TO <i>Arterio-sclerotic CVD.</i>	
		DUE TO <i>Generalized arterio-sclerosis</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 10, 1958</i> to <i>Sept. 8, 1966</i> , that (I) (we) last saw the deceased alive on <i>Sept. 2, 1966</i> , and that death occurred at <i>7:00 AM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>Sept. 8, 1966</i>	
22a. SIGNATURE <i>Bernard O. Thomas Jr.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Bernard O. Thomas Jr.</i>		22d. ADDRESS <i>Frederick, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/9/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Glade</i>		23d. LOCATION (City, town or county) <i>Walkersville, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Barton, Walkersville, md.</i>		25a. REC'D BY REGISTRAR <i>SEP 13 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

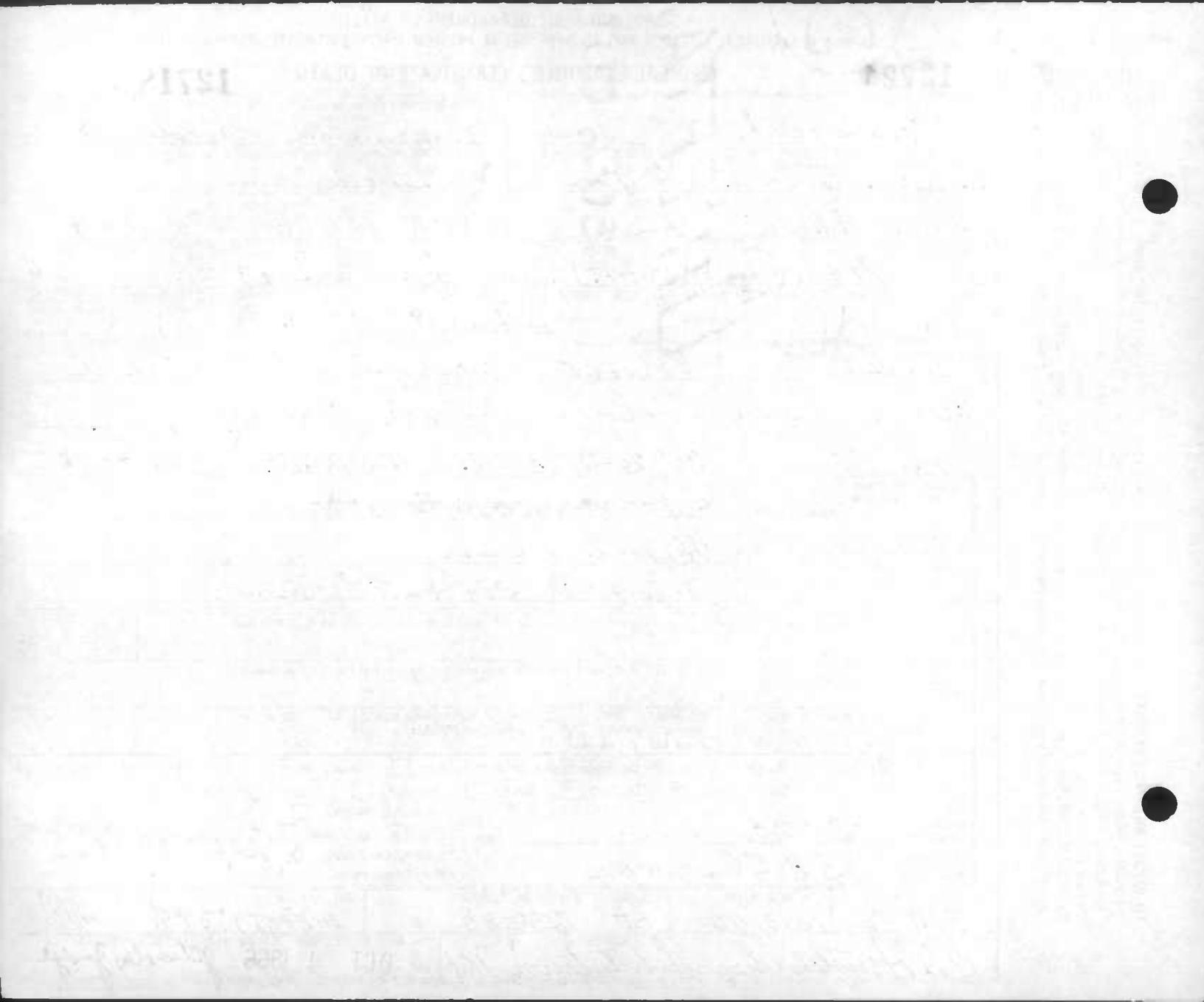
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1272				12718									
1. PLACE OF DEATH a. COUNTY <i>Frederick</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>M. Libertytown</i> c. LENGTH OF STAY IN lb <i>47 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>UNION BRIDGE R2</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>M. Libertytown</i> d. STREET ADDRESS <i>UNION BRIDGE R2</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Henry</i>	Middle <i>Merritt</i>	Lost		4. DATE OF DEATH <i>Sept 30</i>	Month	Day	Year	Day	Year		
S. SEX <i>m</i>	6. COLOR OR RACE <i>Af</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 19, 1917</i>		9. AGE (In years lost birthday) <i>49 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>COLLEGE</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		13. FATHER'S NAME <i>Henry Cunningham</i>		14. MOTHER'S MAIDEN NAME <i>Hazel Bailey</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>347-20-2808</i>		17. INFORMANT <i>ELIZABETH CUNNINGHAM UNION BRIDGE</i>		Address <i>R2 MD</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sub-acute cerebral Hemorrhage</i> DUE TO <i>42000</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Hypertension</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i>													
INTERVAL BETWEEN ONSET AND DEATH													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i></i>		(County) <i></i>		(State) <i></i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
CHIEF MEDICAL EXAMINER <input type="checkbox"/>													
ACTUAL SIGNATURE <i>B. O. Thomas</i>		EXAMINER'S NAME (Type) <i>B. O. Thomas</i>		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <i>Sept. 30, 1966</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10/13/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>ST PETERS</i>		23d. LOCATION (City or Town) <i>LIBERTYTOWN</i>		(County) <i>MD</i>		(State) <i>MD</i>			
24. FUNERAL DIRECTOR <i>D D Hartzler & Sons Libertytown, Md</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>OCT 4 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 (M)

12724

CERTIFICATE OF DEATH

12719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or embalming, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		b. COUNTY Frederick	
c. LENGTH OF STAY IN TB 5 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Ijamsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edgar	Middle W.	Last Davis, Sr.
4. DATE OF DEATH Month Sept. 12, 1966	Day 19	Year 1966	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 13, 1883	9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (County & State, or foreign country) Frederick County, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles G. Davis	14. MOTHER'S MAIDEN NAME Laura Warfield		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 220 34 2369	17. INFORMANT Edgar W. Davis, Jr. Damascus, Maryland	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Hypertensive arteriosclerotic cardiovascular disease (87a) with acute myocardial infarction</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-5- , 19 66 , to 9-12- , 19 66 , that (I) (we) last saw the deceased alive on 8-11- 19 66 , and that death occurred at 4A M, fram causes and an the date stated above.			
22a. SIGNATURE <i>Rex R. Martin</i>	M.D. <input checked="" type="checkbox"/>	ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED Sept. 12, 1966
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.	22d. ADDRESS 220 N. Market Street, Frederick, Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 14, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR Donald M. Etchison	ADDRESS Fallberg	25a. REC'D BY REGISTRAR SEP 15 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/66			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12725		12720	
<p>1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK</p> <p>c. LENGTH OF STAY IN 1b 4 WEEKS</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FREDERICK Memorial Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE RURAL</p> <p>d. STREET ADDRESS —</p>	
<p>3. NAME OF DECEASED First MARGARET Middle JUANITA</p> <p>3. NAME OF DECEASED Last DAVIS</p> <p>4. DATE OF DEATH 9-19-66</p>		<p>Month 09 Day 19 Year 1966</p> <p>e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>5. SEX FEMALE 6. COLOR OR RACE COLORED 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED</p>		<p>8. DATE OF BIRTH JUNE 6, 1910 9. AGE (In years last birthday) 56 yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY OWN HOME</p>	
<p>11. BIRTHPLACE (County & State, or foreign country) MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME GEORGE MILLBERRY</p>		<p>14. MOTHER'S MAIDEN NAME ANNIE HILL</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO</p>		<p>16. SOCIAL SECURITY NO. 219-20-4225</p>	
<p>17. INFORMANT RASCOE DAVIS UNION BRIDGE</p>		<p>Address MD</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 1964</p>	
<p>1533 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca sigmoid Colon (c)</p>		<p>DUE TO OUE TO</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia, Terminal pneumonia</p>		<p>19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18.</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) 8/25/1966 (County) 9/19/1966 (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from 8/25/1966 to 9/19/1966, that (I) (we) last saw the deceased alive on 9/19/1966 and that death occurred at 8 P.M., from the causes and on the date stated above.</p>		<p>22a. SIGNATURE Frank Davis</p>	
<p>22b. DATE SIGNED 8/25/1966</p>		<p>M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>	
<p>22c. PHYSICIAN'S NAME (Type) Frank DAVIS</p>		<p>22d. ADDRESS 700 Mountaineer Frederick</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>		<p>23b. DATE THEREOF 9/22/66</p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL MT Joy</p>		<p>23d. LOCATION (City, town or county) UNIONTOWN MD</p>	
<p>24. FUNERAL DIRECTOR DD Hartzler & Sons Union Bridge</p>		<p>25a. REC'D BY REGISTRAR Charles Judge</p>	
<p>ADDRESS</p>		<p>DATE SEP 22 1966</p>	

1188

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12726

CERTIFICATE OF DEATH

12721

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick Days		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Monrovia	
3. NAME OF DECEASED (Type or print)	LAURA First ELIZABETH Middle	BERR	4. DATE OF DEATH Month Day Year Perr September 19 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 20, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME George Frisby Cartee		11. BIRTHPLACE (County & State, or foreign country) Ellerton, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217 48 3452	
17. INFORMANT John A. Derr, 604 Rosemont Ave. Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary occlusion Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH months years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.		22b. DATE SIGNED Sept. 19, 1966	
22a. SIGNATURE James B. Thomas		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22d. ADDRESS 228 N. Market Street, Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery
24. FUNERAL DIRECTOR Donald M. Etchison		ADDRESS Fredley	23d. LOCATION (City, town or county) (State) Frederick, Maryland
M. R. Etchison & Son, Frederick, Maryland		DATE SEP 22 1966	25a. REC'D BY REGISTRAR Charles Judge

ISSN1



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

12727

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12722

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN lb Since 9/16/58	b. COUNTY <i>Baltimore</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland Odd Fellows Home		d. STREET ADDRESS 1825 Rolling Road	
3. NAME OF DECEASED (Type or print)	First KATHERINE	Middle GORDON	Last DOBEY
4. DATE OF DEATH September 7, 1966	Month Day Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Aug 1880
9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (County & State, or foreign country) Augusta Georgia	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME James R. Kidwell	14. MOTHER'S MAIDEN NAME Katherine M. Gorden	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 212 32 0988A	17. INFORMANT Maryland Odd Fellows Home, Fred'k, Md. 21701	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO (b) Arteriosclerotic Heart Disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1966</u> , to <u>Sept. 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 7 1966</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <i>B. O. Thomas</i>		22b. DATE SIGNED 8 Sept 1966	
22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.	22d. ADDRESS 6-A Watkins Acres, Frederick, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/9/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS National Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR <i>H. R. Smith</i>	25a. REC'D BY REGISTRAR M. R. Etchison & Son, Frederick, Md. 21701	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE SEP 9 1966

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																					
12723 Items 9/13/66 Film G50 CERTIFICATE OF DEATH 12723 Items #4,5,6,8 & 9 Film #4370 9/9/66 DC																					
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)																					
a. STATE		M.D.		b. COUNTY		Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Walkersville											
d. STREET ADDRESS		Main St		Last		4. DATE OF DEATH		Month		Day											
e. IS RESIDENCE ON A FARM?				Sept		3		Year		1966											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print)		First		Middle		5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
Marcie Cleo Eckard						Female		White				July 28, 1879		87 yrs.		Months		Days		Hours	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?															
none				Frederick Md		Md.															
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME																			
William Steinbman		Laura V. Stately																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH											
no		317-32-53678 Clinton Et Eckard				Walkersville Md.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		10 days											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b)		cerebral thrombosis				DUE TO		15 years											
		(c)		arteriosclerotic cv disease																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED?									
Severe osteoarthritis knee under hip												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20e. MEDICAL CERTIFICATION		20d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>																	
21. I certify that (I) (this hospital) attended the deceased from....., 1954 to....., 1966, that (I) (we) last saw the deceased alive on....., 1966, and that death occurred at 10 AM, from the causes and on the date stated above.												22b. DATE SIGNED									
22a. SIGNATURE James E. Stoner, Jr.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED															
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		WALKERSVILLE, Md. 9/6/66																	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)													
Burial Sept 6/66		Church of God				Union Town Md.															
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
J. C. Barton, Walkersville Md.				DATE SEP 7 1966		Charles Judge															
VR A15 (4) 2DM 5-63																					

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Sept 7 1932

6

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12724

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg rural		c. LENGTH OF STAY IN 1b 25 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Victor Davis Miller Fiery		First Victor	Middle Davis
4. DATE OF DEATH Sept. 19 1966	Month Sept.	Day 19	Year 1966
5. SEX male	6. COLOR OR RACE white	7. MARRIED X NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1888
9. AGE (In years last birthday) 78 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. KIND OF BUSINESS OR INDUSTRY Retired	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel L. Fiery	14. MOTHER'S MAIDEN NAME Annie Spickler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No	16. SOCIAL SECURITY NO. 215-36-7144	17. INFORMANT Lillie M. Fiery	Address Emmitsburg, Md. RD 2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral occlusion DUE TO arteriovenous & v.disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. with hypertension (b) General pares DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 15 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9	20f. (City or town) (County) (State) Hagerstown
21. I certify that (I) (this hospital) attended the deceased from June 1950 , to Sept 19 1966 , that (I) (we) last saw the deceased alive on Sept 19 1966 , and that death occurred at 630 M , from causes and on the date stated above.			
22a. SIGNATURE W.R. Cadle	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Sept 20 1966
22c. PHYSICIAN'S NAME (Type) Dr. W.R. Cadle	22d. ADDRESS Emmitsburg, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-22-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Pauls Cemetery Thurmont, Md.	23d. LOCATION (City or Town) (County) (State) Route 40 W. Hagerstown Md
24. FUNERAL DIRECTOR Raymond E. Creager	ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
VR A15 (4) 20 M 1/66	DATE SEP 22 1966		

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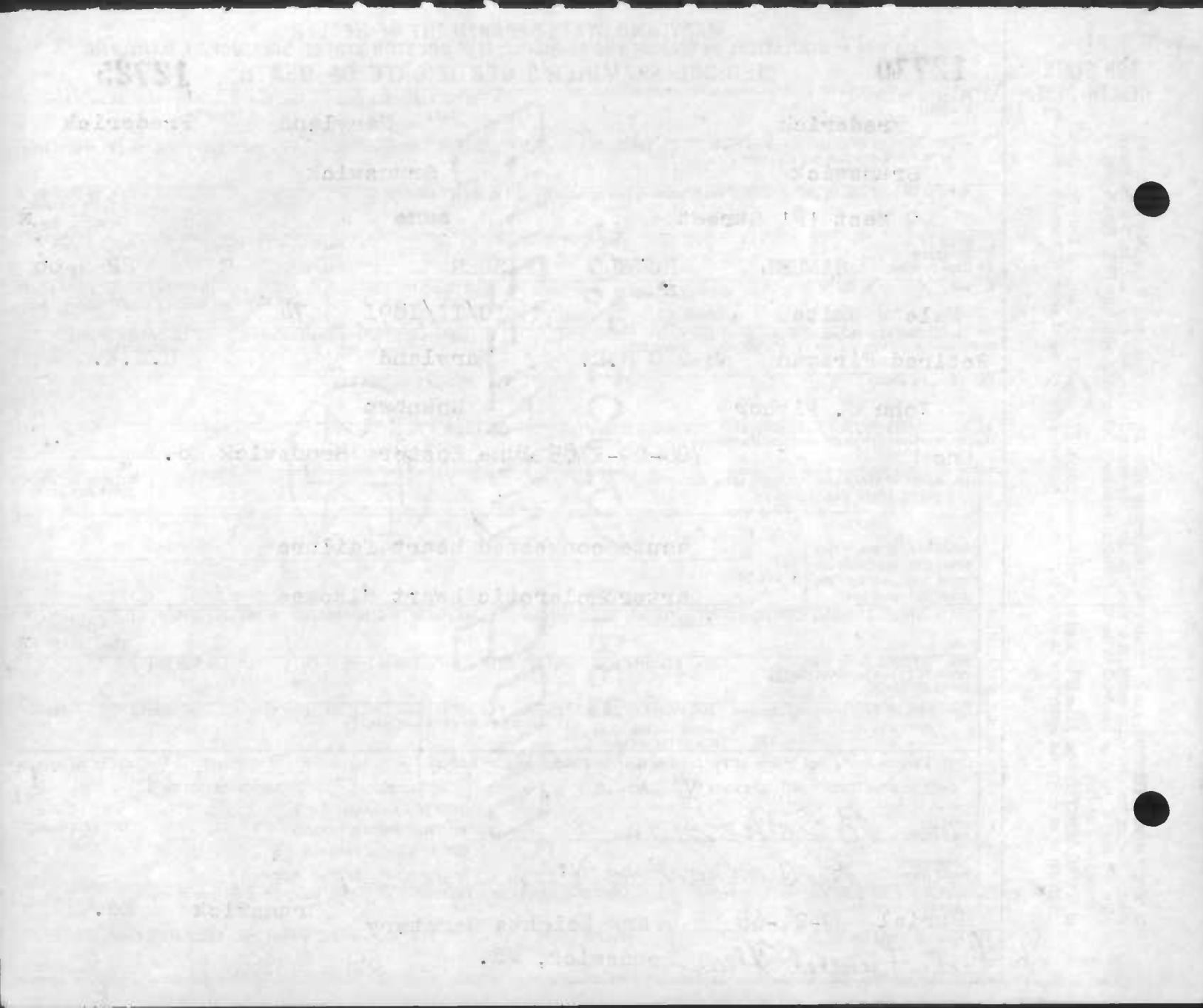
1970-1971

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH																							
12730 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN 1b Brunswick						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9 West 'F' Street																							
3. NAME OF DECEASED (Type or print)			First SAMUEL	Middle HOWELL	Last FISHER	4. DATE OF DEATH 9 Month 22 Day 19 Year 66																	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/II/1891		9. AGE (in years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman						10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.						12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME John W. Fisher						14. MOTHER'S MAIDEN NAME Unknown																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no						16. SOCIAL SECURITY NO. 706-09-1785						17. INFORMANT June Foster Address Brunswick Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute congested heart failure DUE TO (c) arterosclerotic heart disease												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 2dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.						2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)																	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>Br. O. Thomas</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22. DATE SIGNED <i>Br. O. Thomas MD</i>											
EXAMINER'S NAME (Type) <i>Br. O. Thomas MD</i>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 9-24-66						23c. NAME OF CEMETERY OR CREMATORIUM Park Heights Cemetery						23d. LOCATION (City, town or county) Brunswick Md. (State)					
24. FUNERAL DIRECTOR <i>Feele Funeral Home</i>						ADDRESS Brunswick, Md.						25a. REG'D BY REGISTRAR DATE SEP 26 1966						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12731		12726			
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick			
c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Adamstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Route # 1, Adamstown, Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First LUTHER	Middle ROYER	Last FOUCHE		
4. DATE OF DEATH	Month September	Day 11	Year 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 23, 1911		
9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS. Days 4	12. Hours 15		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Operator	10b. KIND OF BUSINESS OR INDUSTRY Store	11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Clarence Fouché		14. MOTHER'S MAIDEN NAME Mae Hovis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 09 6345	17. INFORMANT Mrs. Margaret Fouché (Same as item #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Congestive Heart Failure			
451X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		Ruptured Dissecting Aortic Aneurysm			
		Osteopathic Cystic Medial Necrosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Heart Disease & DS (SD)					
19. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 20g. (County)	20h. (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 14, 1966 , to Sept 11, 1966 , that (I) (we) last saw the deceased alive on Sept 11, 1966 , and that death occurred at 9 A.M. , from the causes and on the date stated above.					
22a. SIGNATURE G. F. Meadors, M. D.		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-11-66	
22c. PHYSICIAN'S NAME (Type) G. F. Meadors, M. D.		22d. ADDRESS 810 Toll House Ave. Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 14, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		23d. LOCATION (City, town or county) Frederick		(State) Maryland	
		25a. REC'D BY REGISTRAR SEP 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 15M 4-64					

3551

101-102

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

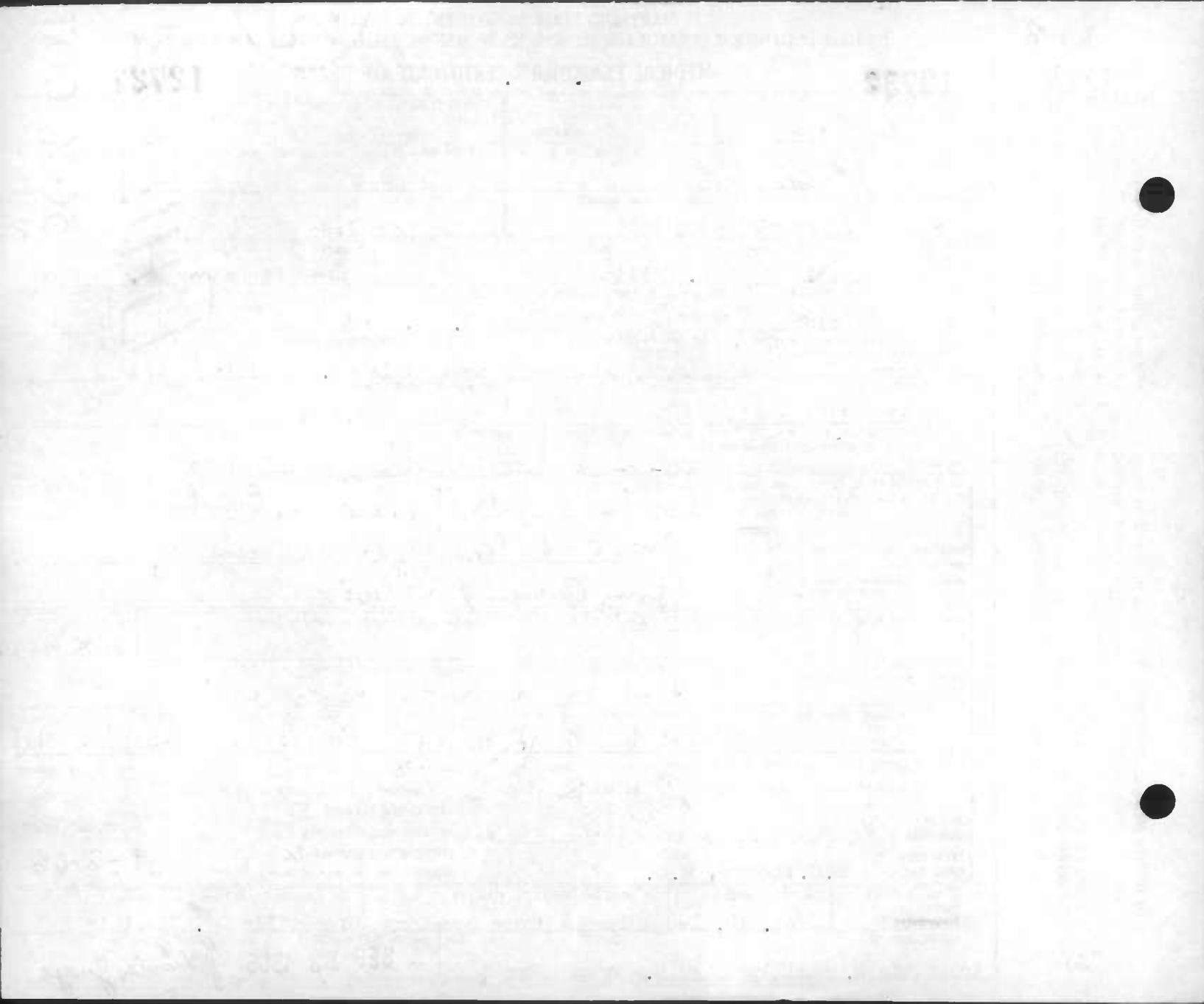
12732
10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12727

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN lb c. LENGTH OF STAY IN lb		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS 2126 Koko Lane		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Cecil	Middle L. Gilliam	Last	4. DATE OF DEATH	Month September Day 8, 1966
5. SEX	6. COLOR OR RACE Male	7. MARRIED Colored	8. DATE OF BIRTH Sept. 20, 1924	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. IF UNDER 24 HRS.
WIDOWED	DIVORCED				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville Co. Virginia	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Marshall Gilliam					
14. MOTHER'S MAIDEN NAME Sallie Williams					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 225-26-3499		17. INFORMANT Pearl Gilliam Address 2126 Koko Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Avulsed Skull, Brain, Crushed INTERVAL BETWEEN ONSET AND DEATH 8161 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Chest & Multiple Fractures of Long Bones & Pelvis (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head-on auto-truck collision			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Longway	
20f. (City or town) Frederick - Frederick - Md		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O.Thomas		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O.Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Sept. 10, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Diamond Grove Cemetery	
24. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monroe Street		ADDRESS		23d. LOCATION (City or Town) Greenville Co. Virginia	
				(County) (State)	
				25a. REC'D BY REGISTRAR SEP 13 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			1273			12728		
1. PLACE OF DEATH a. COUNTY Frederick				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Frederick								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days XXXX				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 243 South Market Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First MARGARET		Middle DELANE		Last GOSNELL		4. DATE OF DEATH September 12, 1966		Month Day Year										
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED		8. NEVER MARRIED X		9. DATE OF BIRTH May 11, 1883		10. ACE (In years last birthday) 83 yrs.		11. IF UNDER 1 YEAR Months Days Hours Min.		12. IF UNDER 24 HRS Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Doubs, Frederick Co. Md.				12. CITIZEN OF WHAT COUNTRY U.S.A.								
13. FATHER'S NAME S. Curtis Michael				14. MOTHER'S MAIDEN NAME Mary Frances Williams																
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-05-0806		17. INFORMANT Mrs. Orval W. Staley		Address 705 Fairview Ave. Md.		Fred.												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i>																				
Ccnditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertensive cardiovascular disease</i>																				
DUE TO (b) <i>Cerebral vascular accident</i>																				
DUE TO (c) <i>Fractured pelvis</i>																				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fractured pelvis</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fractured pelvis</i>																
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)														
19																				
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above.																				
22a. SIGNATURE <i>A. Austin Pearre, Jr.</i>												22b. DATE SIGNED Sept. 12, 1966								
22c. PHYSICIAN'S NAME (Type)		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>														
Dr. A. Austin Pearre, Jr. M.D.												22d. ADDRESS 4 East Church St. Frederick, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-15-1966		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Maryland														
24. FUNERAL DIRECTOR <i>Robert E. Dailey & Son</i>		ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR SEP 15 1966		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>														
VR A15 (4) 20M 1/65																				

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-pass permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12734

12729

1. PLACE OF DEATH		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY		Frederick		a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY	
Frederick				Frederick	
c. LENGTH OF STAY IN lb		Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS	
219 East Third Street				219 East Third Street	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Joseph		Henry		Holdcraft	September 7 1966
5. SEX		6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)
Male		White	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	July 12, 1909	57 yrs.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Rural Mail Carrier		U.S. Government		Frederick, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Henry Holdcraft		Ella Mehrling		U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		W W # 2 214 10 4690		Mrs. Mary Holdcraft (Same as item # 2)	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		Coronary occlusion			
IMMEDIATE CAUSE (a)					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		Arteriosclerotic Heart Disease			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED?	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		September 8, 1966	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
B. O. Thomas, Sr. M. D.		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Burial		Sept. 9, 1966		Mount Olivet Cemetery	
23. FUNERAL DIRECTOR				22d. LOCATION (City, town, or county)	
Donald W. Fadely				Frederick, Maryland	
M. R. Etchison & Son, Frederick, Maryland				24e. REC'D BY REGISTRAR	
				24b. REGISTRAR'S SIGNATURE	
				Date SEP 9 1966 Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Route # 7	
3. NAME OF DECEASED (Type or print) IDA BELLE JAMES		4. DATE OF DEATH Month September Day 1, Year 1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 29, 1884	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Deys	
11. BIRTHPLACE (County & State, or foreign country) Russellville, Alabama		12. IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Henry C. Counts		14. MOTHER'S MAIDEN NAME Mollie J. Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 243-32-0284	
17. INFORMANT Mr. J. C. James, Jr. Route # 7 Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 334X Conditions, if any, which give rise to immediate cause (e), stating the underlying cause first. (b) DUE TO		Hypertensive arteriosclerosis cerebral vascular + with heart disease years	
{ cause first. (c) DUE TO		Rheumatoid arthritis	
{ cause first. (c) DUE TO		Bronchial pneumonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., M, from the causes and on the date stated above.		22b. DATE SIGNED	
22e. SIGNATURE Dr. Rex R. Martin M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Sept. 1, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin M.D.		22d. ADDRESS 220 N Market Frederick Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-4-1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Elmwood Cemetery Frederick, Maryland		23d. LOCATION (City, town or county) (State) Birmingham, Alabama	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son		25a. REC'D BY REGISTRAR DATE SEP 6 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb year		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brooklawn Apts. Apt # 303				d. STREET ADDRESS Brooklawn Apts. Apt. # 303		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First RAYMOND	Middle CECIL	Last KIDD	4. DATE OF DEATH Month September 26,	Day 19 66	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 25, 1889	9. AGE (In years by birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Minutes 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Gov. Official		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (County & State, or foreign country) Urbana, Fred. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Kidd		14. MOTHER'S MAIDEN NAME Jennie S. Cecil					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <i>1918-1919</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Minnie M. Kidd Frederick, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>arteriosclerotic heart dis.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO					
{		DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<i>Severe hypertension 2 stater Possible Pulmonary embolus</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1, 1959</i> , to <i>Sept. 26, 1966</i> , that (I) (we) last saw the deceased alive on <i>Sept. 26, 1966</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.							
22e. SIGNATURE <i>Thomas E. Stone</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9-26-1966
22c. PHYSICIAN'S NAME (Type) Dr. Thomas E. Stone		M.D.		22d. ADDRESS 4 West Third Street Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-28-1966		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Bailey & Son</i>		ADDRESS Frederick, Maryland		25a. REC'D. BY REGISTRAR DATE SEP 29 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12737

CERTIFICATE OF DEATH

12732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights			c. LENGTH OF STAY IN 1b 6 months		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Vindobona Nursing Home			e. STREET ADDRESS 210 Grove Blvd.		
3. NAME OF DECEASED (Type or print) Mary Etta King			4. DATE OF DEATH Month September 21- 19 66	Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25-1886	9. AGE (In years last birthday) 80 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME James William Newcome			14. MOTHER'S MAIDEN NAME Mary Rebecca Jennings		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 261-84-7529		17. INFORMANT Mrs. Glenn T. Swisher-210 Grove Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Carcinoma of Colon INTERVAL BETWEEN ONSET AND DEATH 1 year 1538 DUE TO (b) Liver metastasis 8 mos Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Fred	(County) (State) Frederick, Md.
21. I certify that (I) (this hospital) attended the deceased from Fred , 19 66 , to 21 Sept , 19 66 , that (I) (we) last saw the deceased alive on 14 Sept 1966 , and that death occurred at 6:25 PM , from causes and on the date stated above.					
22a. SIGNATURE Charles H. Conley, Jr.		22b. DATE SIGNED Sept. 21-1966			
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr.		22d. ADDRESS 228 N. Market Street, Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 24-1966	23c. NAME OF CEMETERY OR CREMATORIAL Frederick Mem. Park	23d. LOCATION (City or Town) (County) (State) W. of Frederick, Md.	
24. FUNERAL DIRECTOR M.R. Etchison & Son		ADDRESS Elwood T. Etchison Frederick, Md. 21701	25a. REC'D BY REGISTRAR SEP 27 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12738		12733	
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 231 North Market Street		d. STREET ADDRESS 231 North Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle ELIZABETH	Last LEASE
4. DATE OF DEATH September 30 1966	Month September	Day 30	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 2, 1893
9. AGE (in years last birthday) 73 yrs.	10. KIN OF BUSINESS OR INDUSTRY Clerk	11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Millard F. Lease, Sr.	14. MOTHER'S MAIDEN NAME Fannie G. Danner	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 217 10 9143		17. INFORMANT Miss Katharine Lease (Same as item # 2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Myocardial Infarction DUE TO Conditions, If any, which gave rise to Immediate (b) Arteriosclerotic Heart Disease cause (a), stating the (c) Generalized Arteriosclerosis underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH few min.			
several years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Diabetes Mellitus, moderately severe.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 19 65 to 9/30/66 19 , that (I) (we) last saw the deceased alive on 9/30/66 19 , and that death occurred at 5:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>Gilcin F. Meadows, M.D.</i>		22b. DATE SIGNED Oct. 1, 1966	
22c. PHYSICIAN'S NAME (Type) Gilcin F. Meadows, M. D.		22d. ADDRESS 810 Toll House Ave. Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 3, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery
24. FUNERAL DIRECTOR <i>Donald M. Fadley</i>		ADDRESS M. R. Etchison & Son, Frederick, Maryland	23d. LOCATION (City, town or county) (State) Frederick, Maryland
		25a. REC'D BY REGISTRAR OCT 4 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

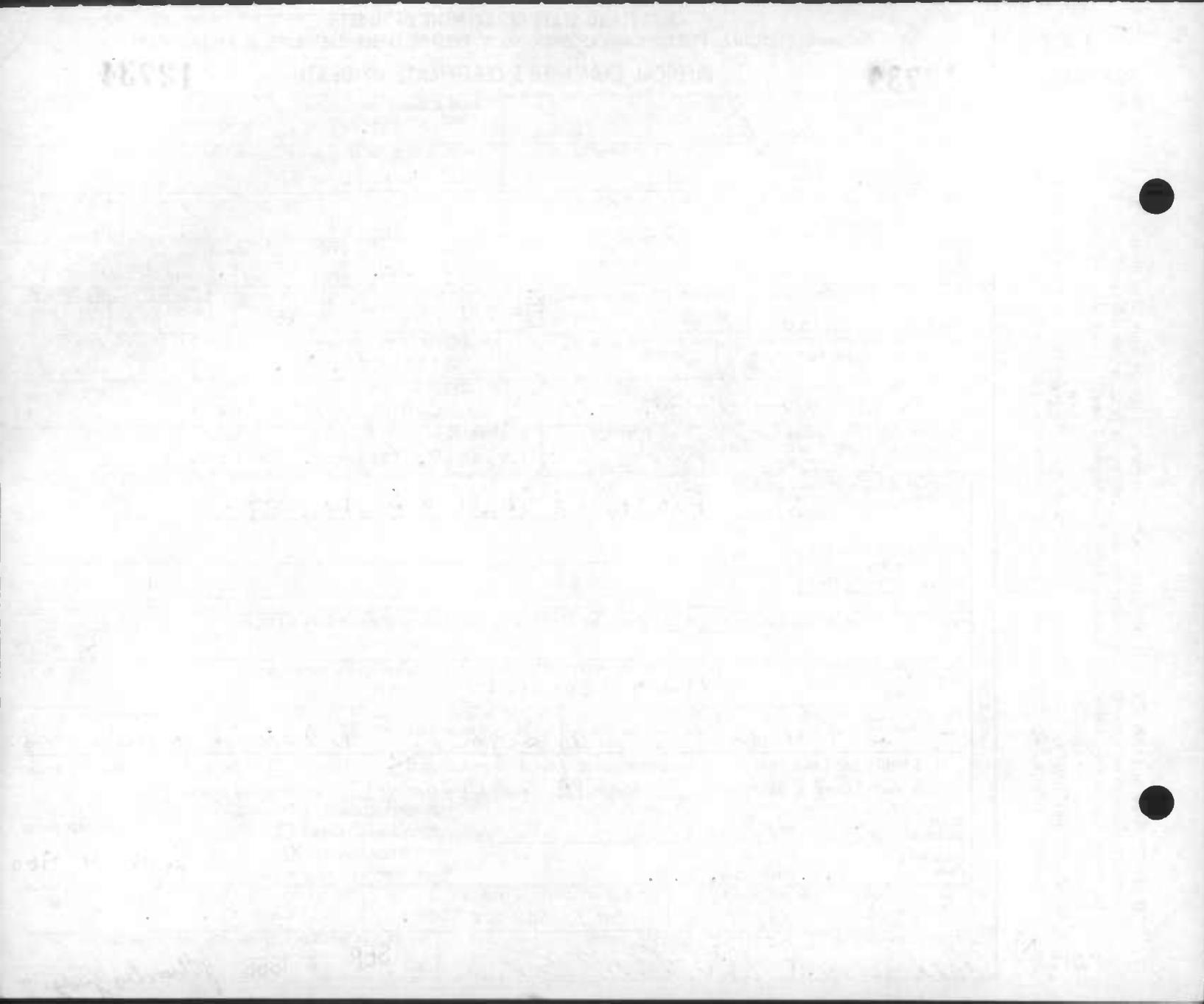
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12734

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Highway</i>		e. STREET ADDRESS Box 42	
3. NAME OF DECEASED (Type or print) First <i>LAMAH</i>		Middle <i>ROY</i>	4. DATE OF DEATH Sept. 4, 1966
S. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> 8. DATE OF BIRTH <i>7/17/50</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY <i>INDUSTRY</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Baltimore, Md.</i>		9. AGE (In years last birthday) yrs. <i>16</i>	
13. FATHER'S NAME <i>Lamah Roy Looney, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Constance Lapinski</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Lamah R. Looney, father, above</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Fractured Skull & Broken Spine</i> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>3 p.m. 9-4 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>Mr. Frederick, Frederick, Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O.Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>B.O.Thomas, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/7/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Redeemer Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR 3331 Brehms Lane ADDRESS <i>Schenmunk Per P.M.S.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 7 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	

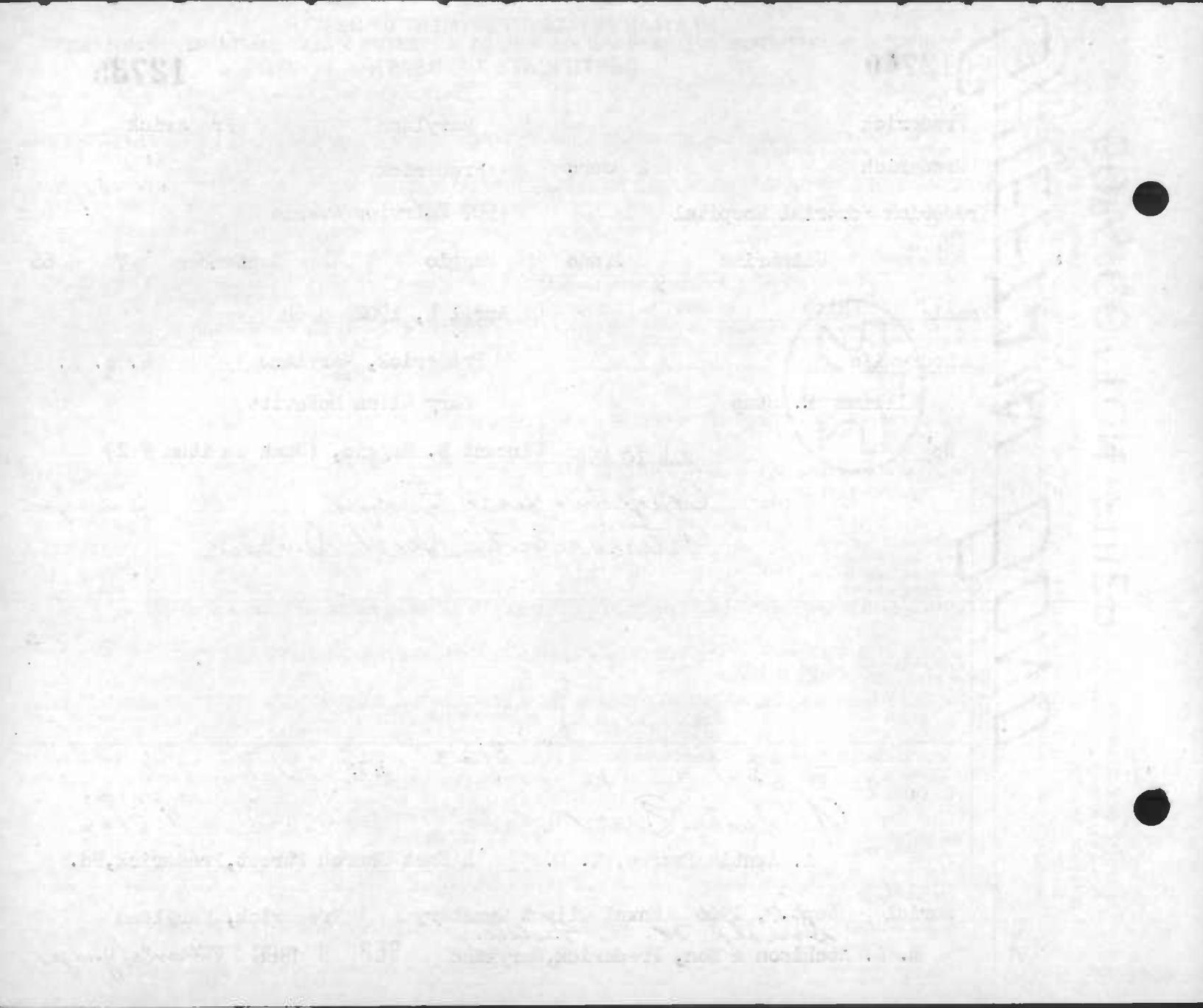


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick									
c. LENGTH OF STAY IN 1b 2 Hours				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 507 Fairview Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Catherine		First	Middle	Last	4. DATE OF DEATH September 7 1966		Month	Day	Year				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH April 4, 1902		9. AGE (In years last birthday) 61 yrs.		10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland					
13. FATHER'S NAME William H. Stup				14. MOTHER'S MAIDEN NAME Mary Ellen McDevitt				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214 10 4588				17. INFORMANT Vincent S. Maggio, (Same as item # 2)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 3 days					
				(b)	DUE TO <i>Congestive Heart Failure</i>								
				(c)	DUE TO <i>Atherosclerotic Heart Disease</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick		(County) Maryland		(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from <u>8/23</u>, 19<u>66</u>, to <u>9/7</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>Sept 7</u>, 19<u>66</u>, and that death occurred at <u>4:45</u> AM, from the causes and on the date stated above.													
22a. SIGNATURE <i>A. Austin Pearre</i>				22b. DATE SIGNED 9/7/66									
22c. PHYSICIAN'S NAME (Type) A. Austin Pearre, M. D.				22d. ADDRESS 4 East Church Street, Frederick, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 9, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Maryland				(State) Maryland	
24. FUNERAL DIRECTOR <i>Donald M. Tedder</i>				ADDRESS M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
DATE SEP 9 1966													



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HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12736

12741

1. PLACE OF DEATH a. COUNTY	Frederick Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	Maryland Frederick Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb	b. COUNTY	
Rural Ladiesburg Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS	Rural Ladiesburg	

3. NAME OF DECEASED (Type or print)	First	Middle	Lost	4. DATE OF DEATH	Month	Doy	Year
Russell Keifer Martz				Sept. 5, 1966	19		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
M.	W.		June 18, 1924	44 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY				
Farmer	owner	Maryland	U.S.A.				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		Address				
Keifer H. Martz	Lula J. Boston		M.E. Keymar				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT					
NO	220-16-3007 Mrs. Wilhelmina Martz	R. P. Keymar					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH
9121	DUE TO	Suffocation	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	(b)		
	(c)	Tractor overturned on chest	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
Farm tractor overturned on deceased		
20c. TIME OF INJURY Month, Doy, Year Hour o.m. Sept. 5, 1966 p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm
		20f. (City or town) (County) (State) Woodbow - Frederick - Md.

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED
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ACTUAL SIGNATURE B.O. Thomas	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED
EXAMINER'S NAME (Type)	B.O. Thomas, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	Agst. 6, 1966
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 8-66	23c. NAME OF CEMETERY OR CREMATORIAL Haugh's	23d. LOCATION (City or Town) Ladiesburg Fred. 11d
24. FUNERAL DIRECTOR J. C. Barton Walkersville Md.	ADDRESS	25a. REC'D BY REGISTRAR SEP 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12742

CERTIFICATE OF DEATH

12737

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick		c. LENGTH OF STAY IN lb 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick County Home			d. STREET ADDRESS Route 6			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mary Irene McMaster		First	Middle	Lost	4. DATE OF DEATH Sept. 14- 19 66	Month Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20-1882	9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11b. KIND OF BUSINESS OR INDUSTRY Companion of sick		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Clay Stauffer			14. MOTHER'S MAIDEN NAME Margaret Jeannette Cramer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-9120		17. INFORMANT Mrs. Donald L. Plunkard-Norva Ave. Frederick-		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arterio-sclerosis DUE TO DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NO. 1	20f. (City or town) AS	(County) SAN JUAN	(State) P.R.
21. I certify that (I) (this hospital) attended the deceased from NOV. 1 , 19 66 , to SEPT. 14 , 19 66 , that (I) (we) last saw the deceased alive on SEPT. 13 , 19 66 , and that death occurred at 2 a.m. from causes and on the date stated above.						
22a. SIGNATURE B.O.Thomas Jr.		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. B.O.Thomas Jr.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Sept. 15-1966		
22c. PHYSICIAN'S NAME (Type) B.O.Thomas- Jr.		22d. ADDRESS Prof. Bldg.- Frederick, Md. 21701				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16-1966	23c. NAME OF CEMETERY OR CREMATORIAL Glade Cemetery	23d. LOCATION (City or Town) (County) (State) Walkersville, Md. 21793		
24. FUNERAL DIRECTOR M.R.Etchison & Son		ADDRESS Elwood T. Whitmore	25a. REC'D BY REGISTRAR Whitmore	25b. REGISTRAR'S SIGNATURE Charles Justice		
DATE SEP 19 1956						

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12743

CERTIFICATE OF DEATH

12738

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN lb Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Nursing Center		d. STREET ADDRESS 225 South Market St.	
3. NAME OF DECEASED (Type or print) Miss Edith	First Miss	Middle Edith	Last Miller
4. DATE OF DEATH Sept 26 1966	Month Sept	Day 26	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED Divorced	8. DATE OF BIRTH June 13- 1890
9. AGE (In years lost, birthday) 76 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No occupation	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Charles Marion Miller		
14. MOTHER'S MAIDEN NAME Fannie Stull	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 219-34-5611		17. INFORMANT Arthur H. Doll-4007 Conn.Ave.N.W.-Wash. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frederick, Md.
20f. (City or town) Frederick		(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from March 31, 1966 , to Sept 26, 1966 , that (I) (we) last saw the deceased alive on Sept 26, 1966 , and that death occurred at 7:25 AM , from causes and on the date stated above.			
22a. SIGNATURE A.A. Pearre, Sr.		22b. DATE SIGNED 9/26/66	
22c. PHYSICIAN'S NAME (Type) Dr. A.A. Pearre-Sr.		22d. ADDRESS Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 29-1966	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son	ADDRESS Whitmore Frederick, Md. 21701	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12744

CERTIFICATE OF DEATH

12739

1. PLACE OF DEATH e. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 304 North College Parkway		d. STREET ADDRESS 304 North College Parkway	
3. NAME OF DECEASED (Type or print) NETTIE		First MAE	Middle NEIL
4. DATE OF DEATH September 23, 1966	Last Month Dey Year	5. SEX Female	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 21, 1882	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months Dey Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker.	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Brunswick, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Virtz	14. MOTHER'S MAIDEN NAME Mary J. Shillings	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 219-07-8895	17. INFORMANT Mrs. Gertrude Glass	18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 4200 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b)		DUE TO Arterosclerotic heart disease Septic ulcer, questionable (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs -	
DUE TO Peptic ulcer, questionable (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mos -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-3-1966 to 9-23-1966, that (I) (we) last saw the deceased alive on 9-22-1966, and that death occurred at 5 AM, from the causes and on the date stated above.	22a. SIGNATURE <i>Rex R. Martin</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 9-23-1966
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin M.D.	M.D.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS 220 North Market Street Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-26-1966	23c. NAME OF CEMETERY OR CREMATORIALy Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Dailey & Son</i>	ADDRESS Frederick, Maryland	25a. REC'D BY REGISTRAR SEP 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
12745						12740							
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN lb 1 yr.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wynelle Nursing Home						d. STREET ADDRESS 324 E. Third St.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Ella M. Middle Null			Lost			4. DATE OF DEATH Sept. 4			Month Day Year 19 66				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1889		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Harne						14. MOTHER'S MAIDEN NAME Lavenia Holt							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Glenn Putman			Address Frederick, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Physical condition of heart</i> DUE TO <i>Interstitial tuberculosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO <i>Interstitial tuberculosis</i> last. (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.													
22a. SIGNATURE <i>Raymond E. Creager</i>						22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-7-66			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Lutheran Cem.			23d. LOCATION (City or Town) (County) (State) Taneytown Carroll Co. Md.				
24. FUNERAL DIRECTOR Raymond E. Creager Thurmont, Md.						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
VR A15 (4) 20 M 1/66									DATE SEP 8 1966		Charles Judge		

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Item 20 Film 381 10-6-66 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

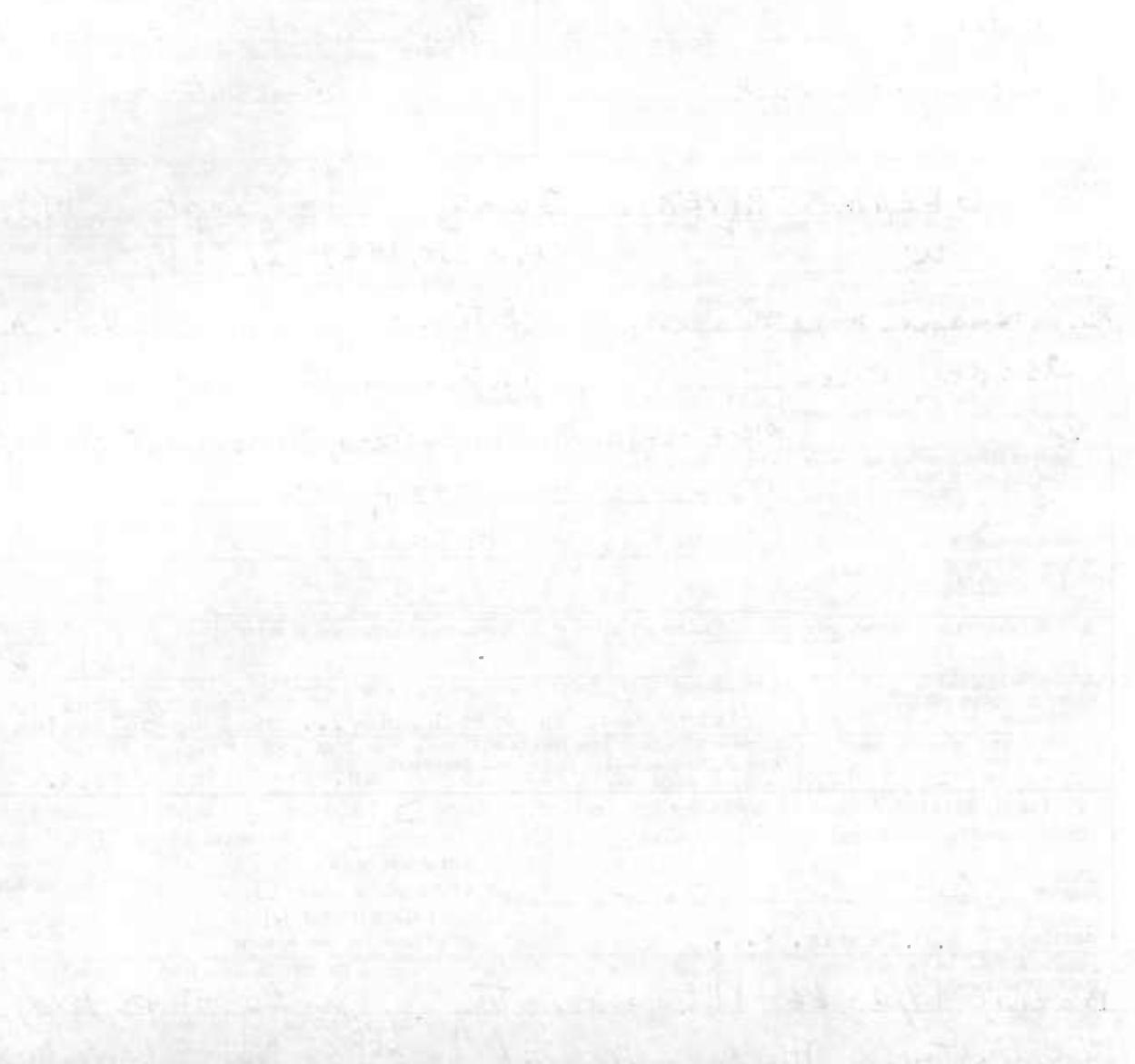
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				12741					
a. COUNTY		Maryland		a. STATE		b. COUNTY							
Frederick		Maryland		Maryland		Frederick							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Highway-Frederick				Levistown				Levistown					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Lost		4. DATE OF DEATH		Month Day Year			
GLENN		RIVER		OURS				Sept. 19 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years lost birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
m		w				Dec. 30, 1924							
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)					
Maintenance man				Gas Co.				Petersburg, W.V.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?					
Isaac Ours				Catherine Crider				U.S.A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No				16. SOCIAL SECURITY NO.				17. INFORMANT Address					
				212-42-0492				Mes Nancy Ours, Silvermount, RI, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Massive Hemothorax				INTERVAL BETWEEN ONSET AND DEATH					
8161 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:													
DUE TO (b)				Avulsed Heart									
DUE TO (c)				Crushed Chest									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Driving East in West bound ... head on collision with tractor trailer				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 9:30 p.m. 9-19 1966				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rte. 15				20f. (City or town) (County) (State) nr. Frederick Fred. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>B.O.Thomas</i>				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) B.O. Thomas, M.D.								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
								Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/23/66				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Utica Cemetery					
24. FUNERAL DIRECTOR J. E. Barton								23d. LOCATION (City or Town) (County) (State) Dr. Levistown, Fred, Md.					
								25a. RECEIVED BY REGISTRAR SEP 26 1966					
								25b. REGISTRAR'S SIGNATURE Charles Judge					

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Ward 10, St. John's, Newfoundland

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12742

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 3 Weeks		a. STATE Maryland b. COUNTY Carroll	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Nursing Home		d. STREET ADDRESS R. D. 2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Mt. Airy	
3. NAME OF DECEASED (Type or print) Harry		First E.	Middle Reaver	Last Reaver	4. DATE OF DEATH Sept 30 1966
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Aug. 1, 1893	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.	
13. FATHER'S NAME Samuel Reaver		14. MOTHER'S MAIDEN NAME Ida B. Warner		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 332-09-1576		17. INFORMANT Mrs. Margaret E. Reaver Same As Above	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 4200					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last.) (b) with congestive failure (c) 1 yr +					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic bronchitis and pulmonary emphysema.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part IV of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 13 1966 , to Sept 30 1966 , that (I) (we) last saw the deceased alive on Sept 30 1966 , and that death occurred at 7:45 PM , from causes and on the date stated above.					
22a. SIGNATURE Henry V. Chase		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 30 Sep 66	
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 804 Toll House Ave Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/1966		23c. NAME OF CEMETERY OR CREMATORIAL Linganore Cemetery	
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		ADDRESS		25a. REC'D. BY REGISTRAR OCT 4 1856	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		12743				
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick Years					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital					d. STREET ADDRESS 241 N. Market St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Harriet First Hilda Middle Rhoderick Last					4. DATE OF DEATH Month 9 Day 4 Year 1966											
5. SEX Female					6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH September 8-1902		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress					10b. KIND OF BUSINESS OR INDUSTRY Restaurant					11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John C. Rhoderick					14. MOTHER'S MAIDEN NAME Amanda Fox											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 214-10-3093					17. INFORMANT Address Irving E. Rhoderick-915 Pine Ave.-Frederick- Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diseasing aortic aneurysm</i>										INTERVAL BETWEEN ONSET AND DEATH 4 weeks						
451X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterosclerotic cardiovascular disease</i> (c)										2 years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from August 24, 1966 , to Sept 4, 1966 , that (I) (we) last saw the deceased alive on Sept 4, 1966 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above.					22a. SIGNATURE <i>LeRoy T. Davis.</i>				22b. DATE SIGNED Sept 4, 1966							
22c. PHYSICIAN'S NAME (Type) LeRoy T. Davis					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22d. ADDRESS Prof. Bldg.- Frederick, Md. 21701						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Sept. 7-1966		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery			23d. LOCATION (City, town or county) (State) Frederick, Md. 21701						
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son					ADDRESS Whitmore Frederick, Md. 21701					25a. REC'D BY REGISTRAR DATE SEP 7 1966				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 20M 1/65																

BLASI

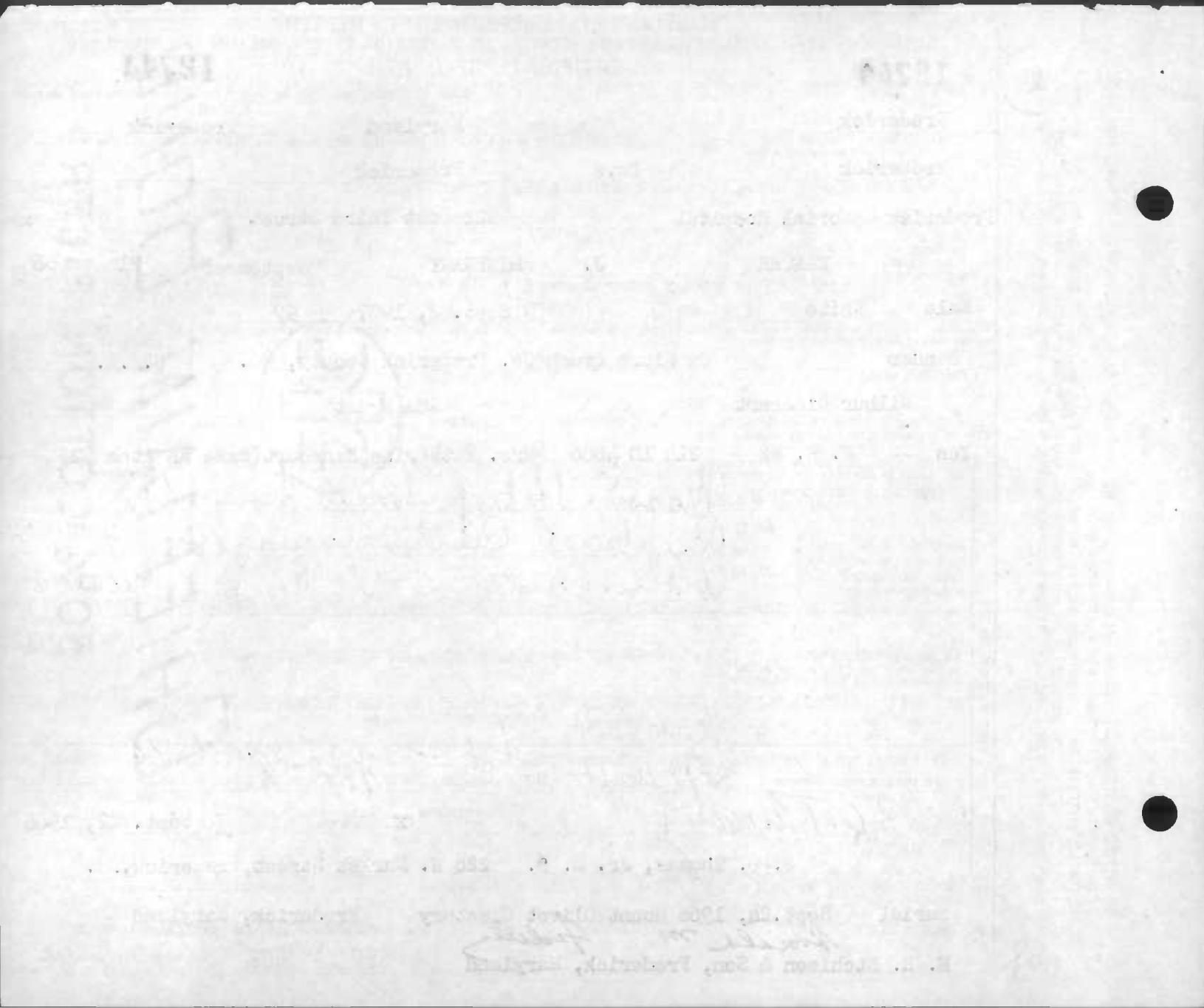
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12743		12744	
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 222 East Third Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WALTER	Middle J.	Last RINEHART
4. DATE OF DEATH	Month September	Day 21	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1907
9. AGE (in years last birthday) 59 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sander	10b. KIND OF BUSINESS OR INDUSTRY Ox Fibre Brush Co.	11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Wilbur Rinehart		
14. MOTHER'S MAIDEN NAME Ada Brust		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. W. #2	
16. SOCIAL SECURITY NO. 211-10-4866		17. INFORMANT Mrs. Katherine Rinehart (Same as item #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Massive Retroperitoneal Hemorrhage 5 minutes	
(b) DUE TO Ruptured Cervical Aneurysm			
(c) DUE TO Arteriosclerotic C-V Disease		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 2</u> , 1966, to <u>Sept 21</u> , 1966, that (I) (we) last saw the deceased alive on <u>Sept 21 1966</u> , and that death occurred at <u>GP</u> M, from the causes and on the date stated above.		22b. DATE SIGNED <u>Sept. 22, 1966</u>	
22a. SIGNATURE <u>B. O. Thomas Jr.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS B. O. Thomas, Jr. M. D. 228 N. Market Street, Frederick, Md.
22c. PHYSICIAN'S NAME (Type)		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 24, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery
24. FUNERAL DIRECTOR Donald M. Etchison		ADDRESS M. R. Etchison & Son, Frederick, Maryland	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE SEP 26 1966 <u>J. Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

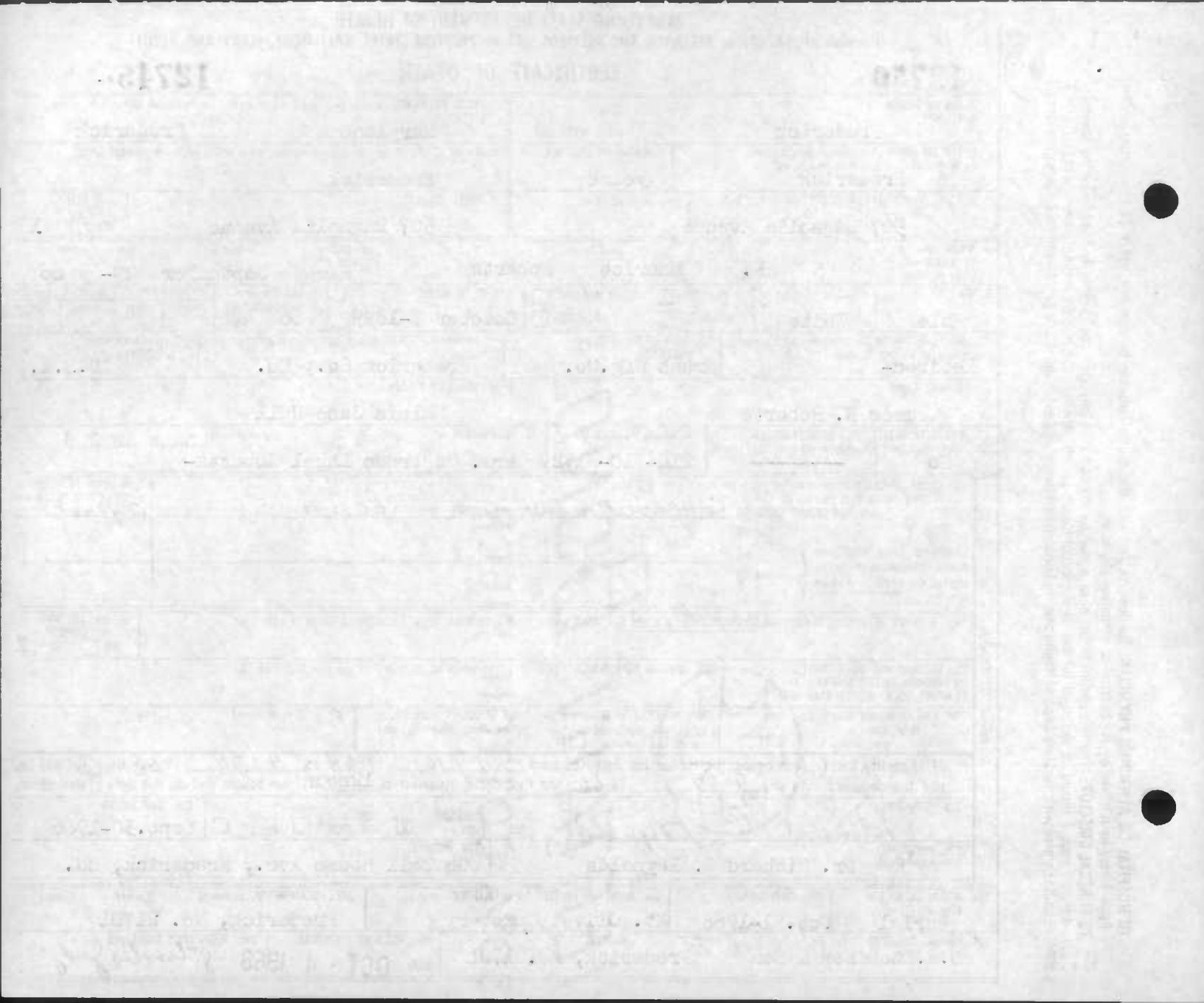
CERTIFICATE OF DEATH

12745

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN Tb years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 507 Magnolia Avenue		d. STREET ADDRESS 507 Magnolia Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First W.	Middle Maurice	Last Roberts
4. DATE OF DEATH	Month September	Day 29	Year 1966
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7-1899
9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-	10b. KIND OF BUSINESS OR INDUSTRY Brush Mfg. Co.	11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME James N. Roberts		
14. MOTHER'S MAIDEN NAME Elsie Jane Null	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-10-1729	17. INFORMANT Mrs. Gertrude Lakel Roberts-	Address Same as 2 d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE RECTUM INTERVAL BETWEEN ONSET AND DEATH 2 years			
154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 804 Toll House Ave., Frederick, Md.
20f. (City or town) (County) (State)			
21. I certify that I (this hospital) attended the deceased from 11/10 , 19 64 to 9/29 , 19 66 that I (we) last saw the deceased alive on 9/27 19 66 , and that death occurred at 12 noon from causes and at the date stated above.			
22a. SIGNATURE Richard C. Reynolds		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED Sept. 30-1966
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds		22d. ADDRESS 804 Toll House Ave., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 1-1966	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son	ADDRESS Whitmore Frederick, Md. 21701	25a. REC'D BY REGISTRAR OCT 4 1966	25b. REGISTRAR'S SIGNATURE J Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12746

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12751		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Frederick		b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville		c. LENGTH OF STAY IN 1b 40 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUSSELL ROY SHANK		4. DATE OF DEATH September 28 1966	Month Doy Year
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH April 9, 1890	9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Painter		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carlton P. Shank		14. MOTHER'S MAIDEN NAME Sarah Rebecca Palmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-36-4805	
17. INFORMANT Hoy H. Shank, 2805 Coldbrook Dr.		Address Washington, D.C. 20021	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		1 month	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerotic Cardiovascular Disease 8 yrs.	
		DUE TO (c) Diabetes Mellitus 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 1114, 1966, to 9-28, 1966
20f. (City or town) (County) (State)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-14 , 1966, to 9-28 , 1966, that (I) (we) last saw the deceased alive on 5-24 1966, and that death occurred at 1114 M, fram causes and an the date stated above.		22b. DATE SIGNED 9-29-66	
22a. SIGNATURE Charles F. Hess		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9-29-66
22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.		22d. ADDRESS Smithsburg, Maryland 21783	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 1, 1966	23c. NAME OF CEMETERY OR CREMATORY Grossnickle's
23d. LOCATION (City or Town) (County) (State)		Myersville, Fred. Co. Md.	
24. FUNERAL DIRECTOR Paul F. Bittle		25a. ADDRESS Paul F. Bittle, Myersville, Md.	25b. REGISTRAR'S SIGNATURE Charles J. Judge
VR A15 (4) 20 M 1/66		25c. REC'D BY REGISTRAR OCT 3 1966	

AFSSI

High Tech Materials

Report

Directions

Advantages

Disadvantages

Advantages

Cost

Efficiency

Cost

Efficiency

Advantages: High Tech Materials are more efficient than traditional materials.

Disadvantages: They are more expensive than traditional materials.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12752		12747	
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 5 mo. 19 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Vindobona Inc.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith		First Middle E. Snyder	Last Last Sept. 26 1966
4. DATE OF DEATH		Month	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	9. AGE (In years last birthday) 89 yrs.
11. BIRTHPLACE (County & State, or foreign country) Browningsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Purdum		14. MOTHER'S MAIDEN NAME Sybelle Browning	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Forrest B. Snyder, Monrovia, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure		INTERVAL BETWEEN ONSET AND DEATH 9 hours	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease		Several Years.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Urinary Infection		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 19, 1966 to Sept. 26, 1966, that (I) (we) last saw the deceased alive on 9/6/66 19, and that death occurred at 3:30 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 9/27/66	
22a. SIGNATURE G. Meadore, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Glen F. Meadore, M.D.		22d. ADDRESS 810 Toll House Ave. Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 29, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Bethesda Meth.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		23d. LOCATION (City, town or county) (State) Browningsville, Md.	
25a. REC'D BY REGISTRAR Charles Judge		25d. REGISTRAR'S SIGNATURE	
DATE SEP 29 1966			

Dogs' abundance

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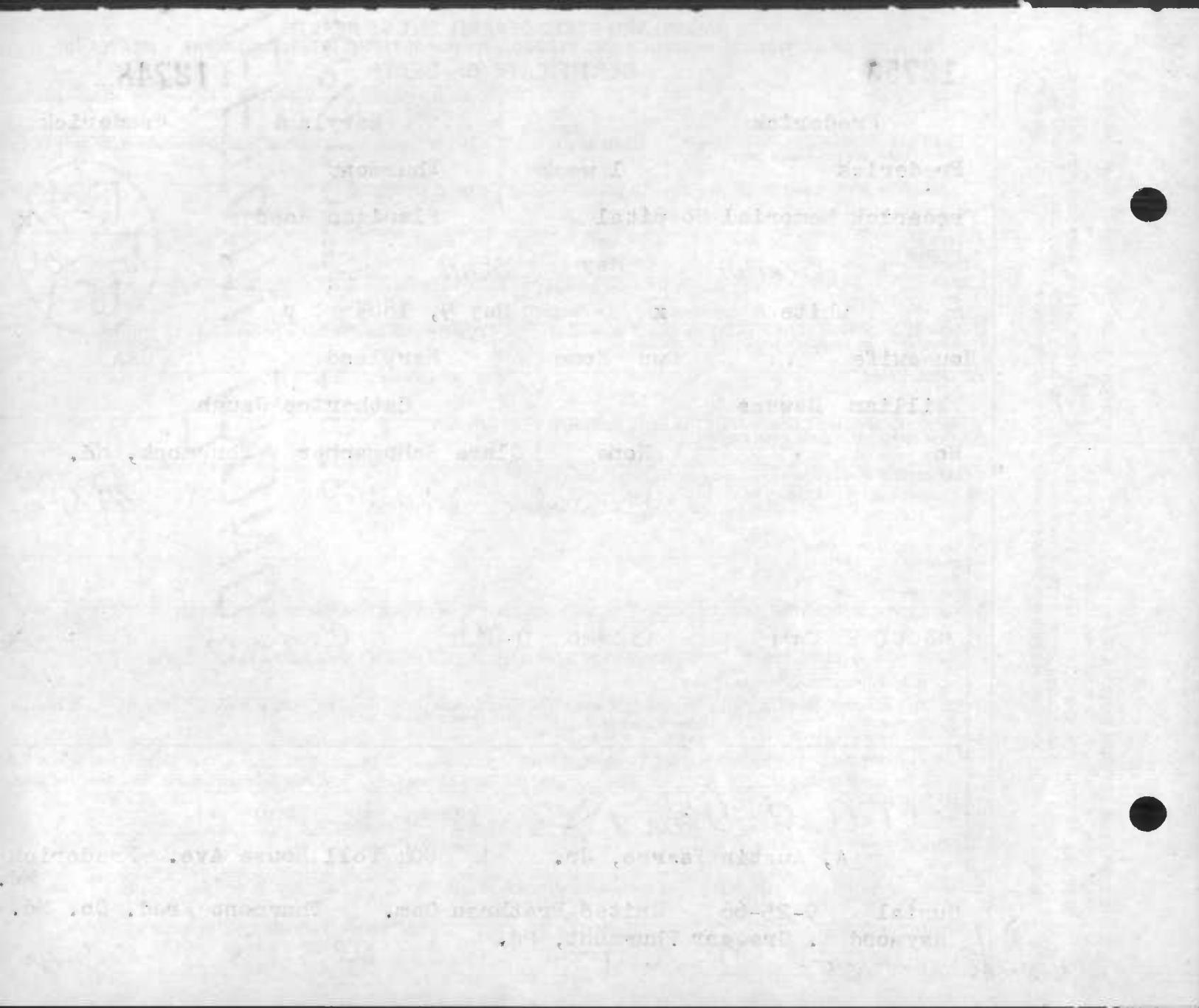
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12753

CERTIFICATE OF DEATH

12748

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 week				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		e. STREET ADDRESS Flanigan Road				
3. NAME OF DECEASED (Type or print) BERTHA		First May	Middle STULL			
4. DATE OF DEATH 9 - 22 1966		Last STULL	Month 9			
5. SEX F		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH May 9, 1885		9. AGE (In years last birthday) 81 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home				
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William Dewees		14. MOTHER'S MAIDEN NAME Catherine Gaugh				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None				
17. INFORMANT Clara Schumacher		Address Thurmont, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary vascular accident 331X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ cause (a), stating the underlying cause last. (c) _____						
INTERVAL BETWEEN ONSET AND DEATH 48 hrs.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASCVD & CHF Diabetes mellitus Ca of cervix						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory, street, office bldg., etc.	20f. (City or town) 804 Toll House Ave.	(County) Frederick	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. SIGNATURE A. Austin Pearre, Jr.		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) A. Austin Pearre, Jr.		22d. ADDRESS 804 Toll House Ave. Frederick				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-25-66		23c. NAME OF CEMETERY OR CREMATORIAL United Brethren Cem.		23d. LOCATION (City, town or county) Thurmont Fred. Co. Md.
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE
20M 1966		DATE SEP 26 1966		DATE		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12749

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson		c. LENGTH OF STAY IN 1b Years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jefferson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson		d. STREET ADDRESS Jefferson			
3. NAME OF DECEASED (Type or print) ROBERT		First MILLER	Middle Thrasher	Lost	4. DATE OF DEATH September 30 1966	Month September	Doy 30	Year 1966	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1893	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 73	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Nurseryman		11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William K. Thrasher		14. MOTHER'S MAIDEN NAME Ella Miller		17. INFORMANT Mrs. Mildred Thrasher (Same as item # 2)		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216 03 8374		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertension & heart disease		DUE TO (b) Generalized arteriosclerosis							
DUE TO (c) Generalized arteriosclerosis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Jefferson	(County) Maryland	(State) MD			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from causes and on the date stated above.					22b. DATE SIGNED Sept. 30, 1966				
22c. PHYSICIAN'S NAME (Type) A. Talbott Brice, M. D.		22d. ADDRESS Jefferson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 3, 1966	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Lutheran Cem.	23d. LOCATION (City or Town) Jefferson, Maryland		(County) Maryland	(State) MD		
24. FUNERAL DIRECTOR Donald M. Etchison		ADDRESS Judeley	25a. REC'D BY REGISTRAR DATE OCT 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				
M. R. Etchison & Son, Frederick, Maryland									

2051

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12755		12750	
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES W. TURNER		4. DATE OF DEATH SEPTEMBER 18 1966	
5. SEX male white		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/13/1886		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) trackman		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Turner		14. MOTHER'S MAIDEN NAME Charlotte McBride	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ellis Turner, Staunton, Va.		Address Route 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 2 days	
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE		DUE TO 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 9/16 1966 , to 9/18 1966 , that (2) (we) last saw the deceased alive on 9/18 1966 , and that death occurred at 4:55 PM , from the causes and on the date stated above.		22b. DATE SIGNED 9/18/66	
22a. SIGNATURE Richard C. Reynolds		22b. DATE SIGNED 9/18/66	
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/21/66	
23c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope Cemetery		23d. LOCATION (City, town or county) (State) Middletown, Md.	
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.		25a. REC'D BY REGISTRAR DATE SEP 20 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1M

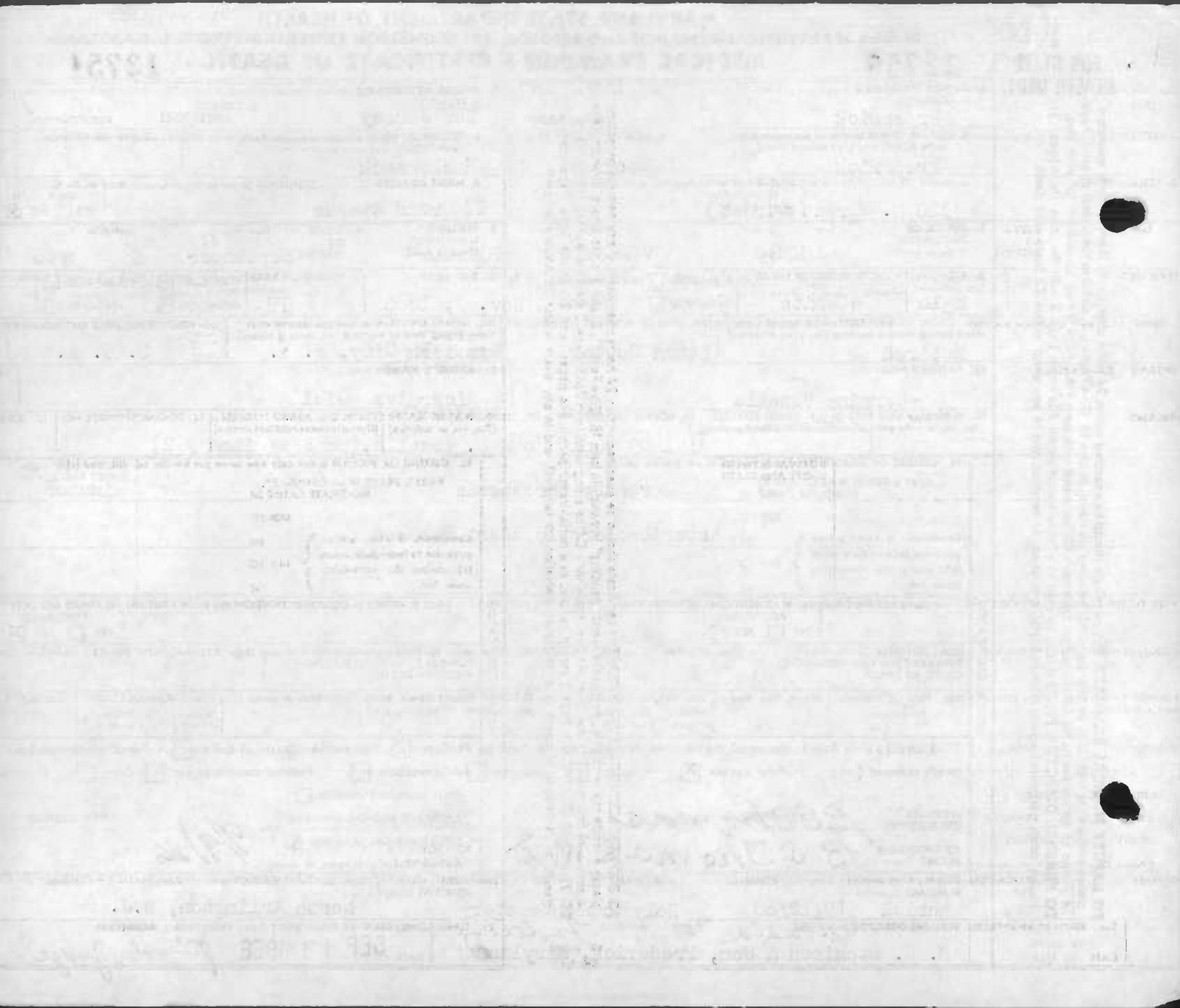
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12756

12751

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Frederick		a. STATE New Jersey	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Bergen	
c. LENGTH OF STAY IN lb Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hackensack	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 320 N. Market Street		d. STREET ADDRESS 22 Grand Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES		4. DATE OF DEATH Month September Day 9 Year 1966	
First VINCENT		Last	
Middle VOZELLA			
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED WIDOWED		8. DATE OF BIRTH Nov. 7, 1886	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 79 Days 0 Hours 0 Min. 11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Stone Cutter	
11. BIRTHPLACE (State or foreign country) Jersey		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Carmine Vozella		14. MOTHER'S MAIDEN NAME Ricardiva Cici	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address 151 09 3061 John S. Vozella, (Same as item # 2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis			
DUE TO (b) Arteriosclerotic Heart Disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>B. Thomas</i> EXAMINER'S NAME (Type) <i>B. Thomas M.D.</i>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>99/66</i>			
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/12/66	
22c. NAME OF CEMETERY OR CREMATORIALy Cross Cemetery		22d. LOCATION (City, town, or county) North Arlington, N.J.	
(State)			
23. FUNERAL DIRECTOR <i>Donald M. Foddeley</i> M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 13 1966 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 M
1275?

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1275?

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Frederick		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lucy Holland		First Lucy	Middle Holland
Last Warfield		4. DATE OF DEATH Sept. 1, 1966	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIOOWEO <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11-25-1883		9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME David Holland		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT Address Mr. Albert Warfield Woodbine, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Cardiac arrest			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Anemia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebrovascular Disease : Coronary Artery Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodbine
20f. (City or town) Woodbine		(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from Aug. 27, 1966 , to Sept. 1, 1966 , that (I) (we) last saw the deceased alive on Sept. 1, 1966 , and that death occurred at 6 P.M. from the causes and on the date stated above.		22b. DATE SIGNED A. Austin Pearre, Jr.	
22a. SIGNATURE A. Austin Pearre, Jr.		M.D. ATTENDING PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) A. Austin Pearre, Jr.		22d. ADDRESS Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-3-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cherry Grove Cemetery
24. FUNERAL DIRECTOR Harry Wm Haight - Sykesville, Md.		25a. REG'D BY REGISTRAR SEP 7 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

8051

888 135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12758

CERTIFICATE OF DEATH

12753

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg, 60 yrs.			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 620 West Main			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Eva	Middle Grace	Last Warthen	4. DATE OF DEATH Sept. 29, 1966	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1903	9. AGE (in years) / IF UNDER 1 YEAR / IF UNDER 24 HRS. 63 yrs.	last birthday Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Liberty Twp. Adams Co. Pa.	
13. FATHER'S NAME John W. Wagerman			14. MOTHER'S MAIDEN NAME Anna M. Knott		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Louis E. Warthen, 620 W. Main, Emmitsburg, Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>atherosclerotic CV disease</i> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/23/66 , 19 66 , to 9/19/66 , 19 66 , that (I/we) last saw the deceased alive on 9/19/66 , 19 66 , and that death occurred at 3 p.m. from the causes and on the date stated above.					
22a. SIGNATURE <i>George L. Moringstar</i>					
22c. PHYSICIAN'S NAME (Type) George L. Moringstar					
22b. DATE SIGNED 9/21/66					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23, 1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. View Cemetery	
24. FUNERAL DIRECTOR Clarence E. Wilson					
25a. REC'D BY REGISTRAR SEP 23 1966					
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

EGS51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Mt. Airy		c. LENGTH OF STAY IN lb 51 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Mt. Airy				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Prospect St.				d. STREET ADDRESS		Prospect St.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	Sept. 5	19	66	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	
Male		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 4, 1889	77 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Farming		Farm		Montgomery Co., Md.		U. S.						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME										
D. Franklin Watkins		Fidelia Reed										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address						
No		212-32-1919		Mrs. Marcia Watkins, Mt. Airy, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH 15 yrs.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Generalized Arteriosclerosis										
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)										
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)					
21. I certify that (I) (this hospital) attended the deceased from.....		July	530	Sept.	19. 66	that (I) (we) last saw the deceased alive on.....	Sept. 5 1966	and that death occurred at 10:30 p.m. the causes and on the date stated above.				
22a. SIGNATURE		<i>William B. Culwell</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Sept. 6, 1966				
22c. PHYSICIAN'S NAME (Type)		William B. Culwell, M.D.		22d. ADDRESS	900 South Main, Mt. Airy, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)				
Burial Sept. 8, 1966				Pine Grove		Mt. Airy, Md.						
24 FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
<i>Olin L. Molson</i>		Damascus, Md.		SEP 9 1966		<i>Charles Judge</i>						

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

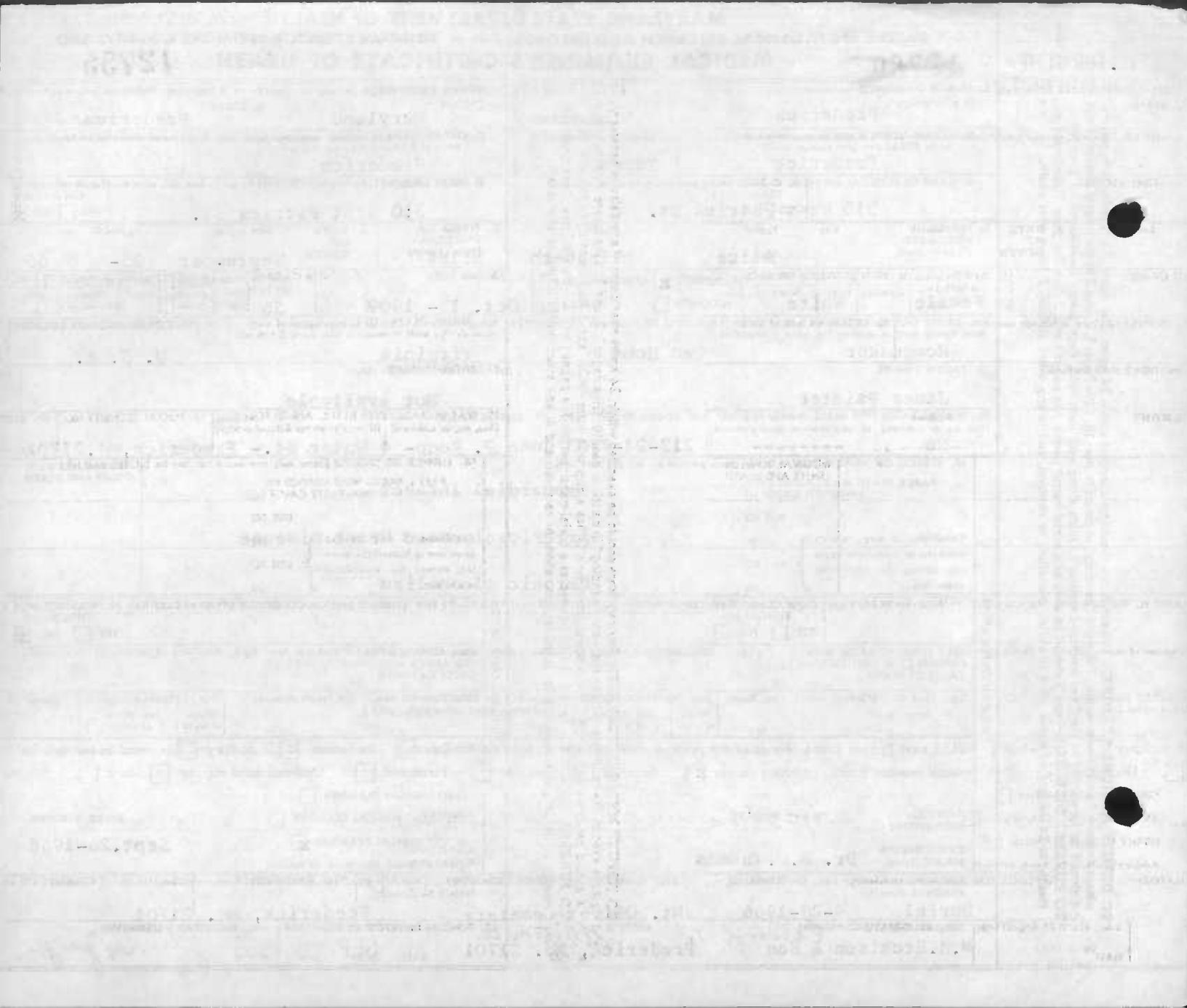
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12760

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12755

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)											
a. COUNTY		a. STATE											
Frederick		Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY											
Frederick		Frederick											
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
Years		Frederick											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS											
310 West Patrick St.		310 West Patrick St.											
e. IS RESIDENCE ON A FARM?													
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First	Middle										
Alice			Elizabeth										
3. NAME OF DECEASED (Type or print)		Last											
Wiles													
4. DATE OF DEATH		Month	Day										
September		25-	19 66										
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>										
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										
8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.									
Oct. 13- 1909		56 yrs.	Months	Days	Hours	Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY							
Homemaker		Own Home		Virginia		U. S. A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Not available		Address							
James Painter													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
No		213-24-7703		John P. Roop- 4 Water St.- Frederick, Md. 21701		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
Myocardial Infarct		DUE TO		Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO		Chronic Alcoholism									
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		Month, Day, Year	Hour a.m.	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
				19			p.m.	While at work <input type="checkbox"/>	Not While at work <input type="checkbox"/>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
								M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Sept. 26-1966	
ACTUAL SIGNATURE <u>Beth Thomas</u>								EXAMINER'S NAME (Type) Dr. B.O. Thomas		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
Burial		9-28-1966		Mt. Olivet Cemetery		Frederick, Md. 21701							
23. FUNERAL DIRECTOR		ADDRESS		Whitmore		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
M.R. Etchison & Son		Frederick, Md. 21701				SEP 30 1966		Charles Judge					
DATE													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12761 12756

1. PLACE OF DEATH a. COUNTY Federick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Hospital				d. STREET ADDRESS Rt. 144 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle F.	Last WILLIAMS	4. DATE OF DEATH SEPTEMBER 19 1966	Month SEPTEMBER	Day 19	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-1894	9. AGE (in years last birthday) 72 yrs.	10. IF UNDERTAKER 11. BIRTHPLACE (County & State, or foreign country) Lincoln, Neb.	12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lincoln, Neb.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Godfrey Luthy				14. MOTHER'S MAIDEN NAME Lennette Ludi			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. ?	17. INFORMANT Mrs. Doris Miller, Rt. 144	Address Woodbine, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA							
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) CHRONIC PYONEPHRITIS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/30 , 19 66 , to 9/19 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9/19 , 19 66 , and that death occurred at 2nd fl M, from the causes and on the date stated above.							
22a. SIGNATURE Richard C. Reynolds,		22b. DATE SIGNED 9/19/66					
22c. PHYSICIAN'S NAME (Type)		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-22-1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Johns		23d. LOCATION (City, town or county) (State) Ellicott City, Md	
24. FUNERAL DIRECTOR F.C. Higinbotham		25a. REC'D BY REGISTRAR DATE SEP 21 1966 25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12762

CERTIFICATE OF DEATH

12757

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 5 Months		c. LENGTH OF STAY IN lb Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Nursing Center		d. STREET ADDRESS 613 Magnolia Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HAROLD	Middle REEVES	Last YARROLL
4. DATE OF DEATH	Month SEPTEMBER	Day 22	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH August 27, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (County & State, or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Yarroll		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) Yes WW # 1		16. SOCIAL SECURITY NO. 218 30 8916	
17. INFORMANT		Address Mrs. Charlotte W. Yarroll (Same as item #2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 3 Days			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) old " " (c) Diabetes mellitus 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Diabetes mellitus	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 11, 1966 , to Sept 22, 1966 , that (I) (we) last saw the deceased alive on Sept 22, 1966 , and that death occurred at 11 AM , from causes and on the date stated above.			
22a. SIGNATURE Thomas E. Stone		22b. DATE SIGNED 9-22-66	
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.		22d. ADDRESS 4 West Third St. Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 24, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery	23d. LOCALITY (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
		DATE SEP 26 1966	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12763

CERTIFICATE OF DEATH

12758

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b days	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 5 Mt. Olivet EXXX Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HERMAN	First XXXXX	Middle YOUNG	Last
4. DATE OF DEATH September 25, 1966	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1894
9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1917-1919	
17. INFORMANT Mr. John Callas		Address 5 Mt. Olivet Blvd. Fred. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute antroseptal myocardial infarction DUE TO (b) Osteosclerotic cardiovascular disease Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
INTERVAL BETWEEN ONSET AND DEATH 10 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 8, 1966, to Sept 25, 1966, that (I) (we) last saw the deceased alive on Sept 25, 1966, and that death occurred at 11:59 P.M., from the causes and on the date stated above.			
22a. SIGNATURE LeRoy T. Davis		22b. DATE SIGNED Sept 26, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. LeRoy T. Davis M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 228 N. Market St. Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-28-1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		Arlington National Cemetery Ft. Myer, Virginia	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Frederick, Maryland DATE SEP 29 1966	

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